

## SOFTWARE SAFETY

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## OUTLINE

- 1) Introduction to Software Safety
- 2) Basic System Safety Principles
- 3) Planning a Software Safety Program
- 4) Software Hazard Analysis Techniques
- 5) Safe Software Design Principles
- 6) Verification of Safety

## INTRODUCTION TO SOFTWARE SAFETY

- What is Software Safety?
- What is its relationship to other software qualities?

## Real-Time Safety-Critical Systems

When computers are used to control complex, time-critical mechanical devices or physical processes such as:

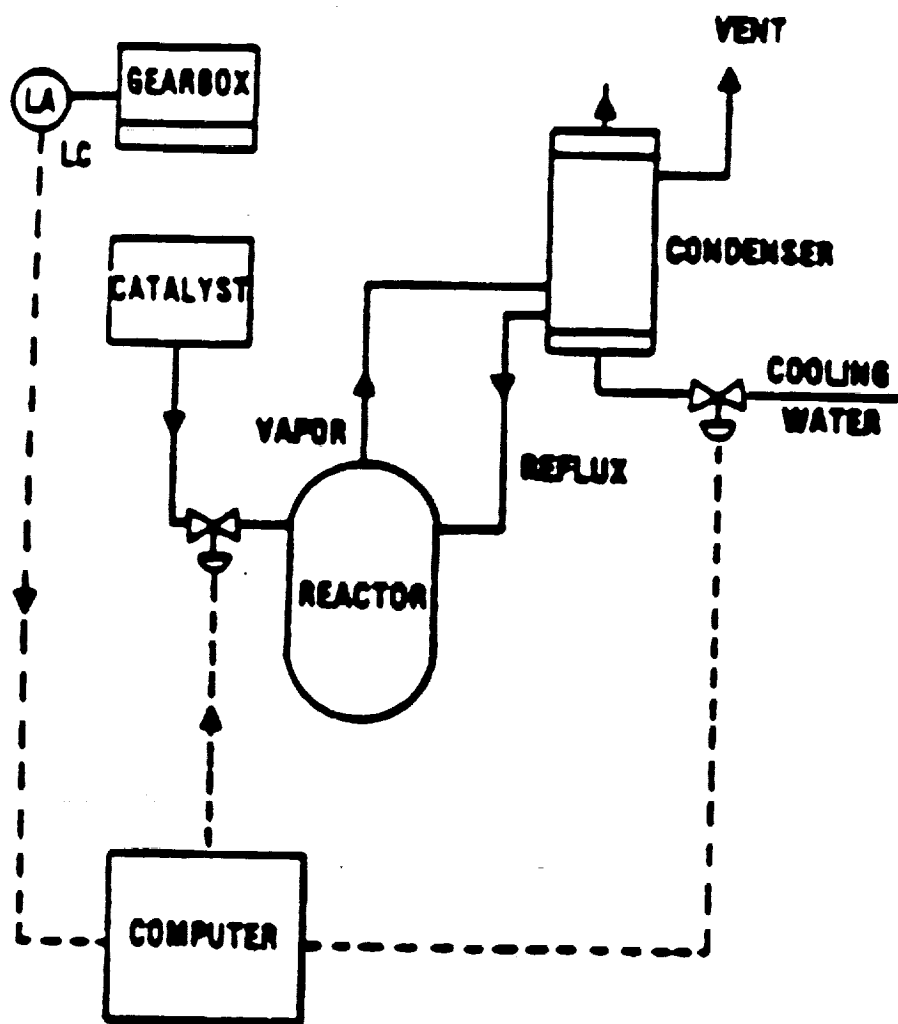
Air Traffic

Nuclear Fission

Hospital Patient Monitoring

Defense and Aerospace Systems

where a run-time error or failure can result in death, injury, loss of property, environmental harm.



**Figure 1. A computer-controlled batch reactor**

### Facts about accidents:

- Most accidents originate in system interfaces. Caused by complex, unplanned interactions between components of the system.
- Accidents often involve multiple failures of different components.
- System accidents intimately intertwined with complexity and coupling.

### COMPUTER-INVOLVED ACCIDENTS:

*Almost all due to inadequate design foresight and requirements specification*

- *incomplete or wrong assumptions about about operation of controlled system or required operation of computer*
- *unhandled controlled-system states and environmental conditions*

### **Goals in building complex systems:**

- **attaining mission (functional correctness)**
- **preventing undesired events while attempting to achieve the mission (safety, security)**
- **minimizing cost**

### **Focusing on safety separately from other goals:**

- **Allows for conflict resolution and decisions about tradeoffs**
- **Allows differential handling of erroneous states**
- **Provides discipline and procedures for looking for errors**
- **Focuses attention and assigns responsibility**
- **Allows measuring and ensuring safety separately from other goals**

## Implications and Challenges for Software Engineering

- Requirements for software safety analysis and verification being included in contracts and by government licensing agencies.
- New standards for safety-critical software.
- National and international working groups
- Safety involves multiple areas of traditional software research along with safety engineering.

reliability

security

**SYSTEM RELIABILITY:** considers problems concerned with ensuring system will perform a required task or mission for a specified time in a specified environment.

**SYSTEM SAFETY:** considers problems of not causing an accident in the process.

- Usually many system failures which can occur without causing a mishap
- Sometimes even conflicts between functional and safety requirements

## Relationship between Safety and Security

- Both involve threats
- Both are negative requirements
- Both are system qualities
- Both may require high levels of assurance

Are they the same?

advertent vs. inadvertent actions

## BASIC SYSTEM SAFETY PRINCIPLES

- What is System Safety?
- System Safety Analysis Techniques

## SYSTEM SAFETY ENGINEERING

The application of scientific, management, and engineering principles to ensure adequate safety within the constraints of operational effectiveness, time, and cost throughout the system life cycle.

### HAZARD ANALYSIS

- Identify hazards
- Assess risk

### HAZARD CONTROL

- Eliminate hazards
- Minimize hazard occurrence or effects
- Document and track hazards and progress made toward resolution of associated risk.

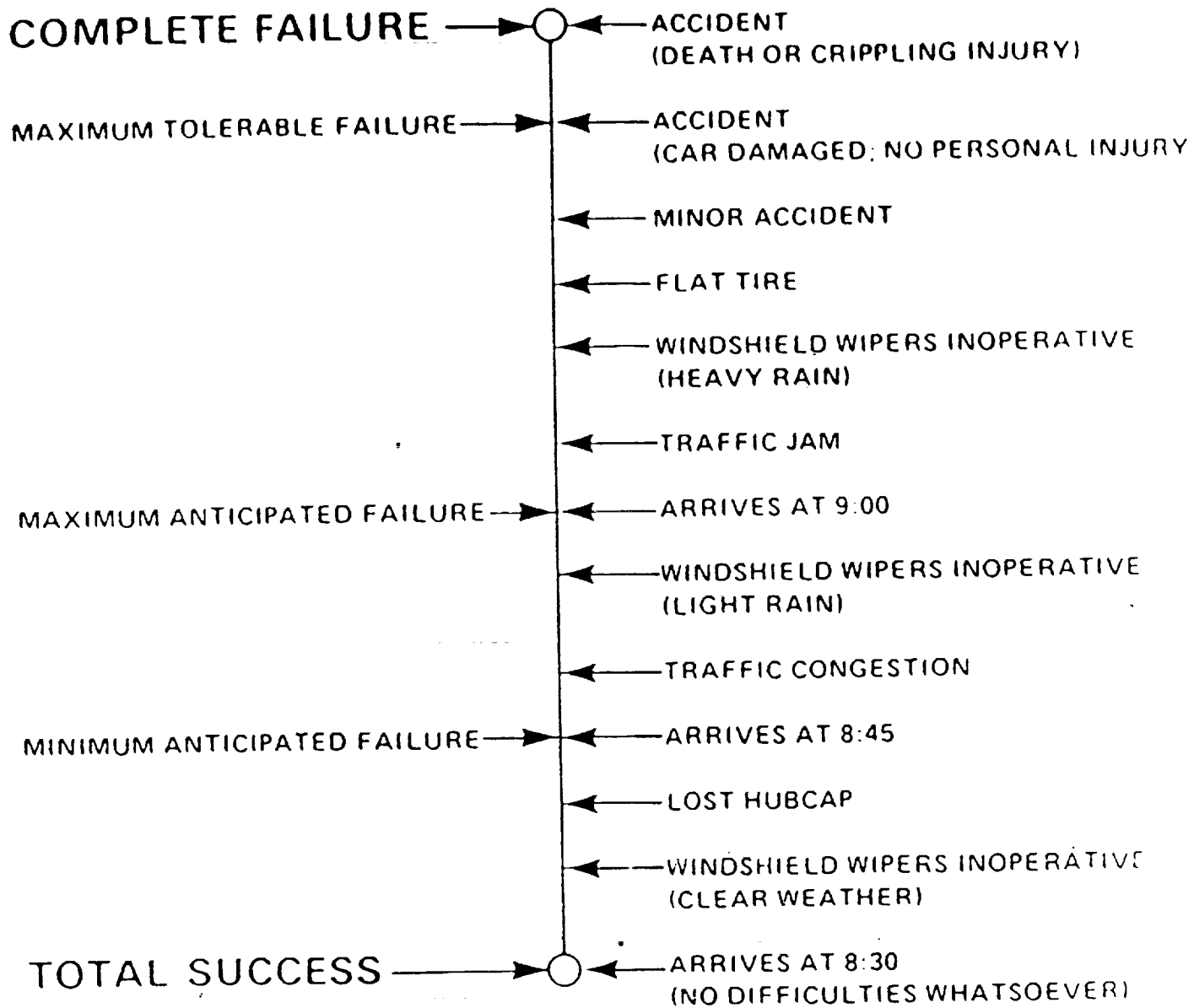
***Preliminary Hazard Analysis (PHA):***

- **identify safety-critical areas and functions**
- **identify and evaluate hazards in terms of severity and likelihood**
- **identify safety design criteria to be used**

**Results used in:**

**developing system safety requirements**

**preparing performance and design specifications**



## HAZARD SEVERITY

### **MIL-STD-882B. System Safety Program Requirements:**

Category I. Catastrophic: may cause death or system loss.

Category II. Critical: may cause severe injury, severe occupational illness, or major system damage.

Category III. Marginal: may cause minor injury, minor occupational illness, or minor system damage.

Category IV. Negligible: will not result in injury, occupational illness, or system damage.

### **NHB 5300.4 (1.D.1), a NASA document:**

Category 1. Loss of life or vehicle (includes loss or injury to public).

Category 2. Loss of mission (includes both postlaunch abort and launch delay sufficient to cause mission scrub).

Category 3. All others.

### **DOE 5481.1 (nuclear):**

Low. Hazards that present minor on-site and negligible off-site impacts to people or the environment.

Moderate. Hazards that present considerable potential on-site impacts to people or environment, but at most only minor off-site impacts.

High. Hazards with potential for major on-site or off-site impacts to people or the environment.

## HAZARD PROBABILITY

- Described in terms of occurrences per unit of time, events, population, items, or activity.
- Derive from modelling or from historical safety data from similar systems.

***Subsystem Hazard Analysis (SSHA):***

- Identify hazards associated with design of subsystems including:
  - component failure modes
  - critical erroneous human inputs
  - hazards resulting from functional relationships between components of the subsystem
- Determine how operating or failure modes of components affects safety of the system.
- Identify necessary actions to determine how to eliminate or reduce risk of identified ~~actions~~ hazards.
- Evaluate design with respect to safety requirements of subsystem specification.

### ***System Hazard Analysis (SHA):***

- Identify hazards created by interfaces between subsystems or by system operating as a whole including human errors.
- Examines all subsystem interfaces for
  - (a) compliance with safety criteria in system requirements specification.
  - (b) possible combinations of independent, dependent, and simultaneous hazardous events or failures, including failures of controls and safety devices, that could cause hazards.
  - (c) degradation of safety of system from normal operation of system and subsystems.

***Operating and Support Hazard Analysis (OSHA):***

- identify hazards and risk reduction procedures during all phases of system use and maintenance.
- especially examines hazards created by man/machine interface.

## **ANALYSIS TECHNIQUES**

**Design reviews and walkthroughs**

**Checklists**

**Fault Tree Analysis (FTA)**

**Event Tree Analysis (or Incident Sequence Analysis)**

**Hazard and Operability Studies (HAZOP)**

**Random Number Simulation Analysis (RNSA)**

**Failure Modes and Effects Analysis (FMEA)**

## INDUCTIVE APPROACHES

- reasoning from individual to general
- determine what system states possible
- postulate particular fault or initiating condition + attempt to ascertain effect on system operation

e.g. how will loss of some particular control surface affect flight of aircraft

- for complex systems, impossible to identify all possible component failure modes

- when subsystems put together, new failure modes may appear

## DEDUCTIVE APPROACHES

- reasoning from general to specific
- determine how given system state can occur
- postulate system has failed in certain way + try to find out what behavior could cause or contribute to it

e.g. plane crashes, what could have caused it?

- difficult to find all cause sequences

## **SYSTEM SAFETY DESIGN PROCEDURES**

**GOAL:** Eliminate identified hazards or, if not possible, reduce associated risk to an acceptable level.

**Order of precedence for applying safety design techniques:**

**(1) Intrinsically safe design**

**(2) Prevent or minimize occurrence of hazards.**

**e.g. monitoring**

**automatic control (automatic pressure relief valves,  
speed governors, limit-level sensing controls)**

**lockouts**

**lockins**

**interlocks**

**(3) Control hazard if it occurs using automatic safety devices.**

**detection of hazards**

**fail-safe designs**

**damage control**

**containment**

**isolation of hazards**

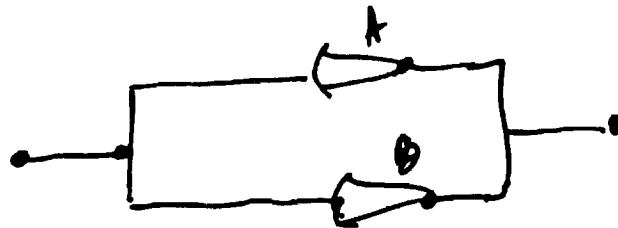
**(4) Provide warning devices, procedures, and training to help personnel react to hazard.**

Interlock - ensures a sequence of operations occurs in correct order

- 1) ensure event A does not occur inadvertently
- 2) ensure event A does not occur while condition C exists
- 3) ensure event A occurs before event D

# FMEA example

1	2	3	4	5
Component	Failure Probability	Failure Mode	% Failures by Mode	Effects Critical      Non-Critical
A	$1 \times 10^{-3}$	Open	90	X ( $5 \times 10^{-5}$ )
		Short	5	
		Other	5	
B	$1 \times 10^{-3}$	Open	90	X ( $5 \times 10^{-5}$ )
		Short	5	
		Other	5	



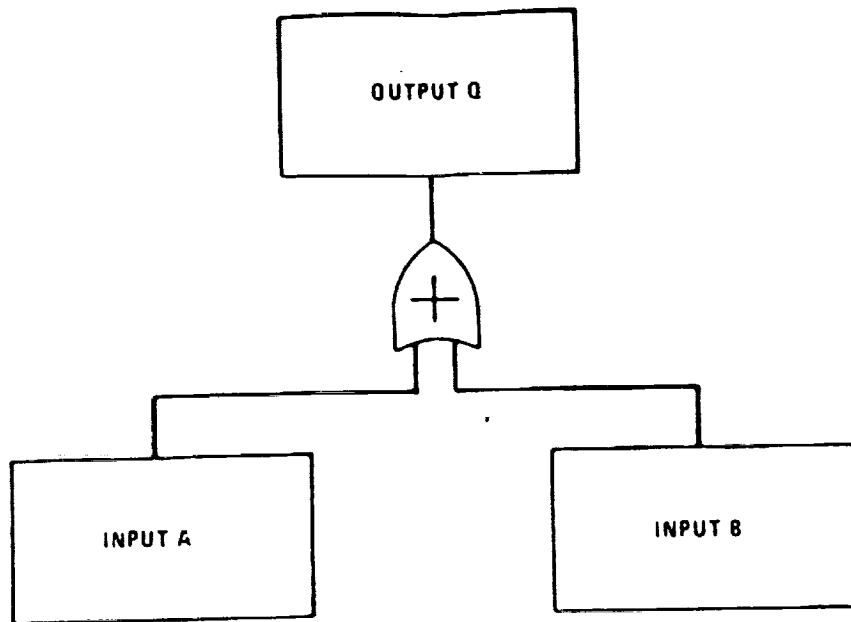


Figure IV-2. The OR-Gate

It is important to understand that causality never passes through an OR-gate. That is, for an OR-gate, the input faults are never the causes of the output fault. Inputs to an OR-gate are identical to the output but are more specifically defined as to cause. Figure IV-3 helps to clarify this point.

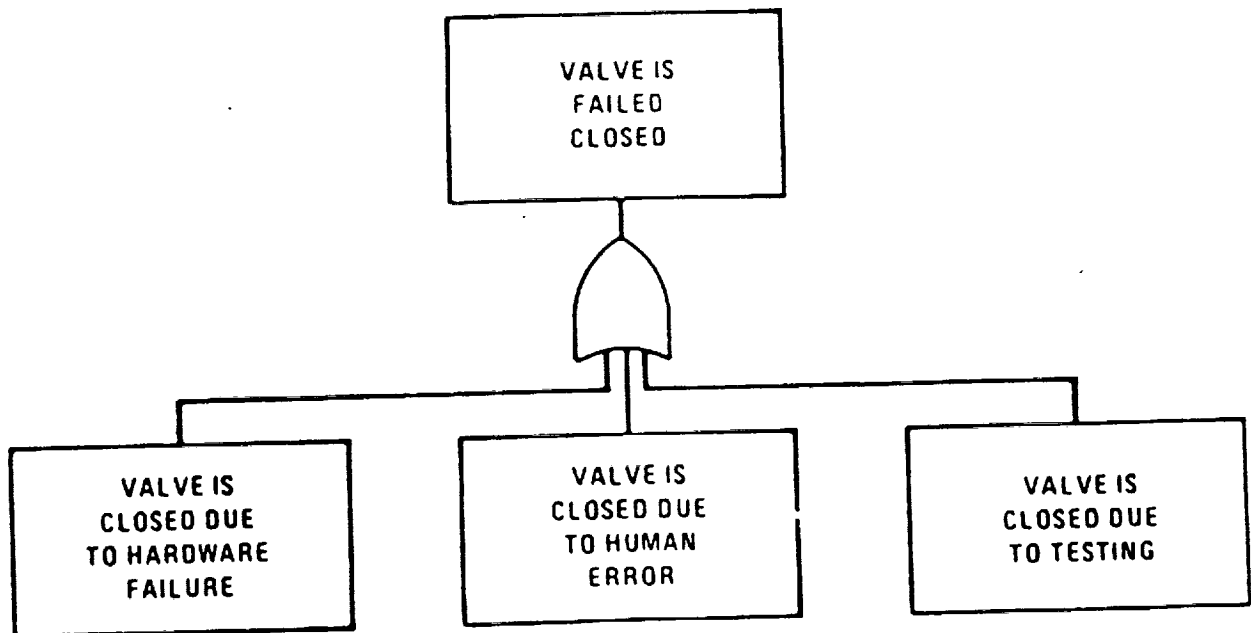


Figure IV-3. Specific Example of the OR-Gate

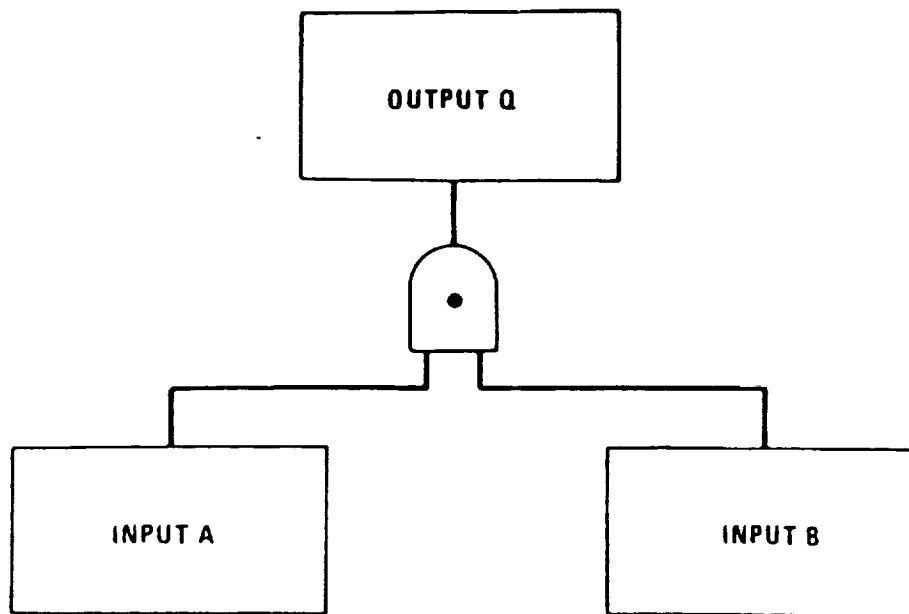


Figure IV-5. The AND-Gate

In contrast to the OR-gate the AND-gate does specify a causal relationship between the inputs and the output, i.e., the input faults collectively represent the cause of the output fault. The AND-gate implies nothing whatsoever about the antecedents of the input faults. An example of an AND-gate is shown in Figure IV-6. A failure of both diesel generators and of the battery will result in a failure of all onsite DC power.

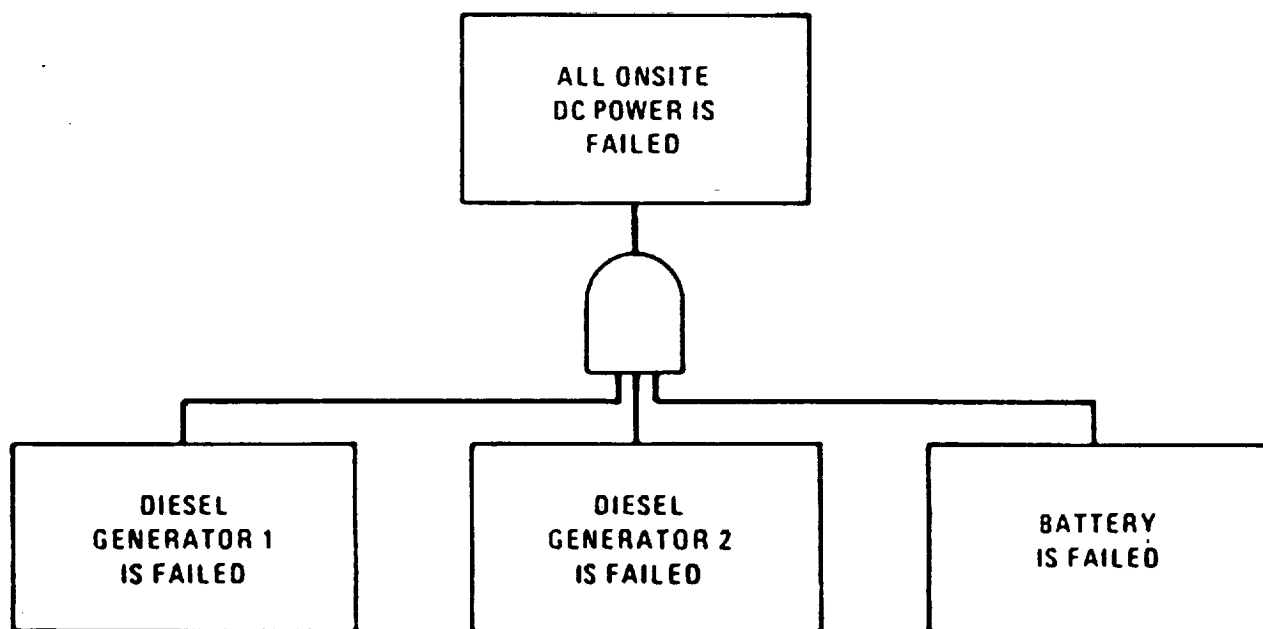


Figure IV-6. Specific Example of an AND-Gate

Quantitative modelling using fault trees:

- Attach probabilities to nodes of tree.
- Use boolean algebra to calculate minimal cut sets.

*minimal cut set:* All unique combinations of events that can cause the top-level event.

## A Sample Software Safety Program

- Software Development Management Responsibilities
- Software Hazard Analysis
- Establishing Software Safety Requirements
- Software Safety Requirements Review
- Software Safety Design Concepts
- Software Design and Recovery Analysis
- Software Safety Design Review
- Code Verification and Validation
- Assessment of Risk

*Software Safety:* involves ensuring that the software will execute within a system context without resulting in unacceptable *risk*.

Risk is defined in terms of *hazards* -- states of the system that when combined with certain environmental conditions *could* lead to a mishap.

$$\text{Risk} = f ( \text{Pr [hazard occurs]}, \text{Pr [hazard leads to mishap]}, \\ \text{Severity of worst potential mishap} )$$

*Safety critical software:* software which can directly or indirectly cause or allow a hazardous system state to exist.

## GENERAL COMMENTS

- Safety must be specified and designed into software from the beginning.
- Effective safety programs require changes throughout entire software life cycle.
- Enhancing reliability is not enough.
- The success of any software safety effort hinges on the ability of software, system, and safety engineers to cooperate and work together.

## Basic approach adapted from system safety engineering

### 1) Identify potential software-related hazards

*(hazard: A condition or state of the system with the potential for leading to an accident)*

### 2) Control hazards

- Analysis

Start from hazard and work backward  
to see if and how could occur.

- Design

Passive Control

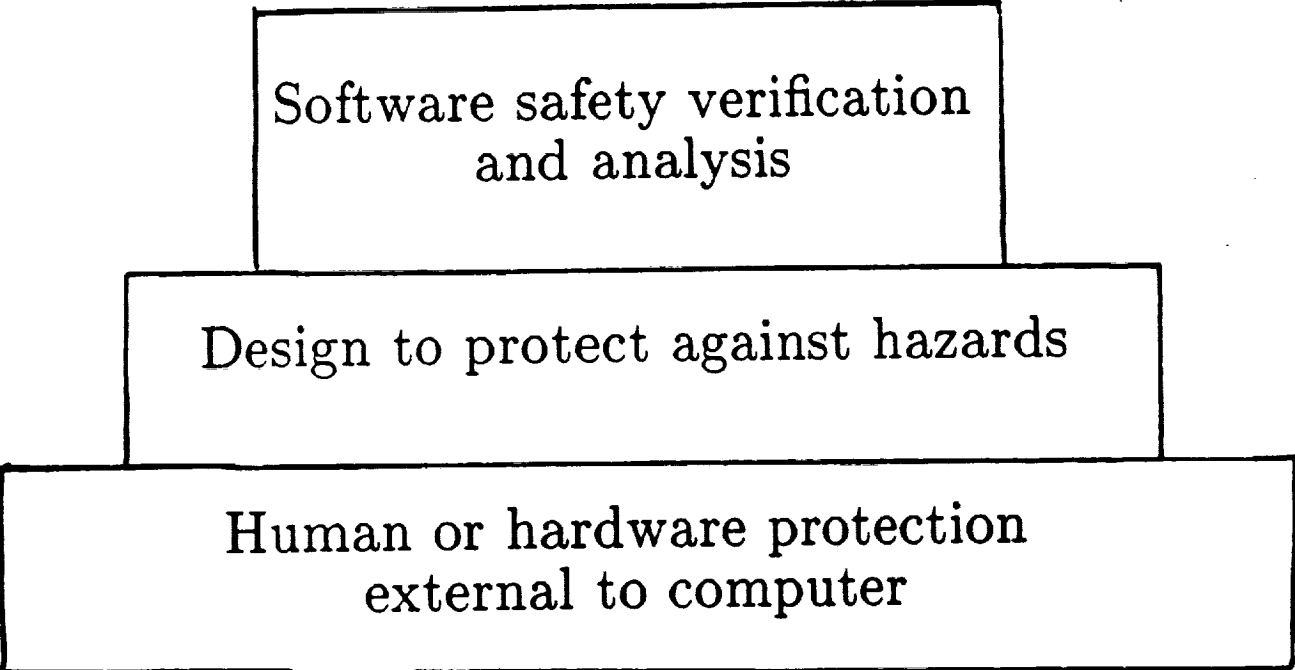
Active Control

## *Philosophy and Goals*

Building a bridge between software engineering and system engineering.

- Use modeling and analysis for understanding and prediction
- A systems approach — well-defined interfaces with hardware engineers, systems engineers, and quality assurance groups.
- Focus on failures with the most serious consequences
- Layers of protection

## Layers of Protection



Software safety verification  
and analysis

Design to protect against hazards

Human or hardware protection  
external to computer

- Integrate into usual software development process

Activities span the life cycle.

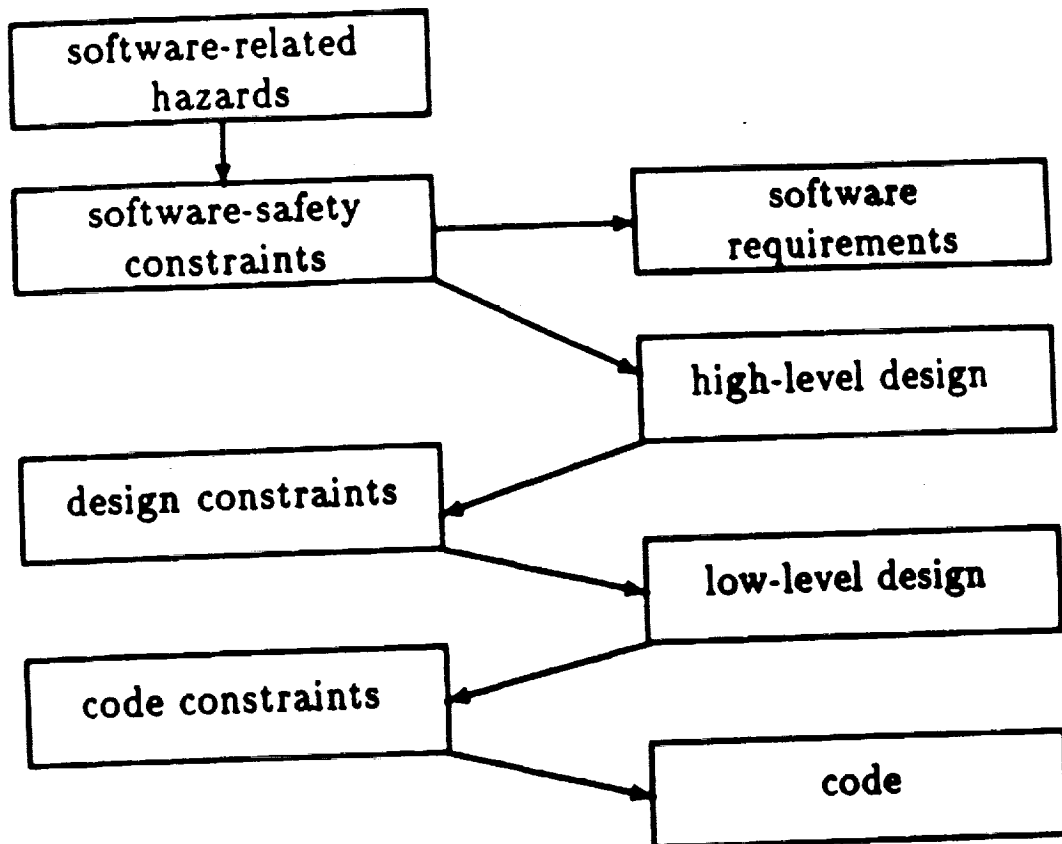
Catch errors early — verification distributed throughout development.

Information derived from early activities (modeling and analysis) is used to drive the design and coding.

- Combine formal and informal approaches

Static analysis using formal proofs and structured walkthroughs

Dynamic analysis to provide confidence in the models and assumptions used in the static analysis.



## CAVEATS

- No magic potions
- Nothing is absolutely safe
- No techniques are perfect
- Risk elimination vs. risk displacement
- Nothing is safe under all conditions

## MANAGEMENT

*Management commitment to safety is the most crucial requirement for achieving it.*

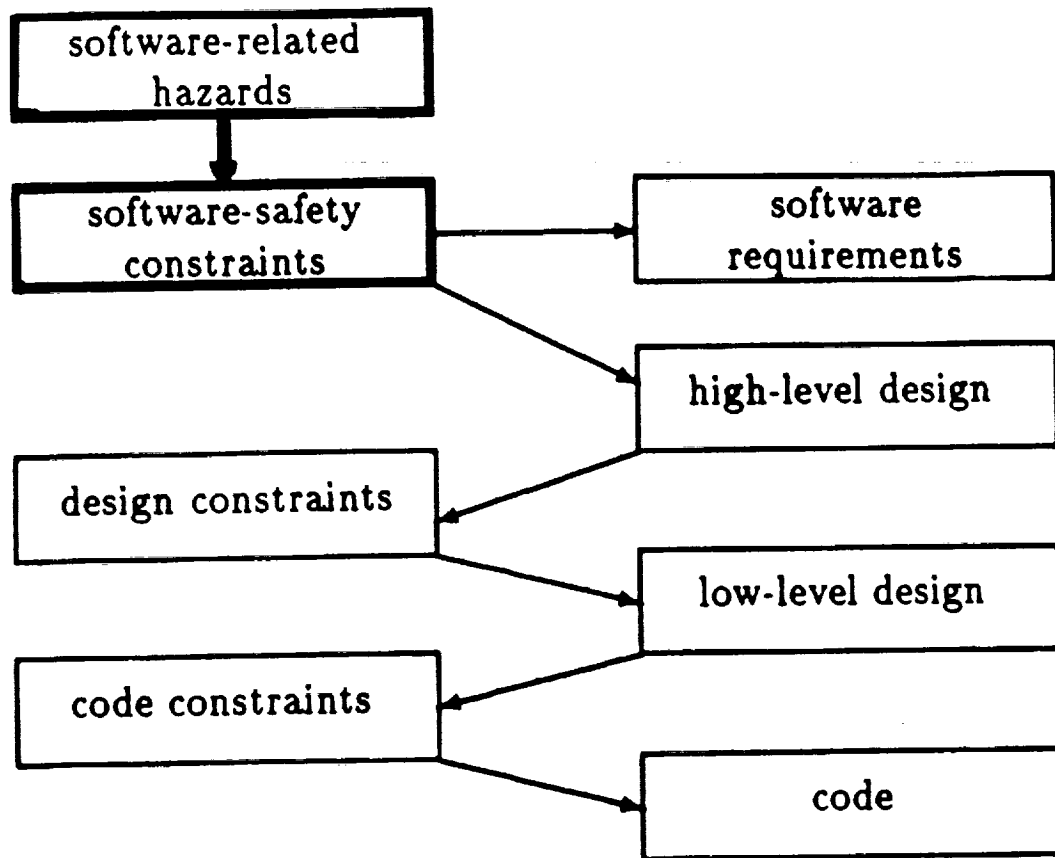
- degree of safety achieved is directly dependent upon emphasis given to it.
- goals of safety can be accomplished only with the support of management.

Need to:

- set policy and define goals for software safety
- delegate responsibility
- grant authority
- fix accountability
- clearly delineate lines of authority, cooperation, and administration

**General responsibilities of software safety management and personnel:**

- **Participation in early planning of the safety program**
- **Continual close interaction with system safety group during the life of the program**
- **Participation in all aspects of the software development activities to ensure that software hazards are eliminated or controlled to an acceptable level.**



## **Software Hazard Analysis**

- Model the software/system interface
- Analysis to identify software-related hazards
- Integrate with system safety analysis and system engineering models and analysis.

## SOFTWARE HAZARD ANALYSIS

- 1) If operates “correctly,” will any hazardous states result?
- 2) If there are failures, will hazards result?

Single failures?

Multiple failures?

## Fault Tree Analysis

- A graphic model of the various parallel and sequential combinations of faults (or system states) that will result in the occurrence of a predefined undesired event.
- Events can involve hardware failures, human mistakes, software design faults, computer hardware failures, etc.
- Start with list of system hazards (PHA). Assume hazard has occurred, and work backward to determine set of possible causes. Preconditions described with either AND or OR relationships.

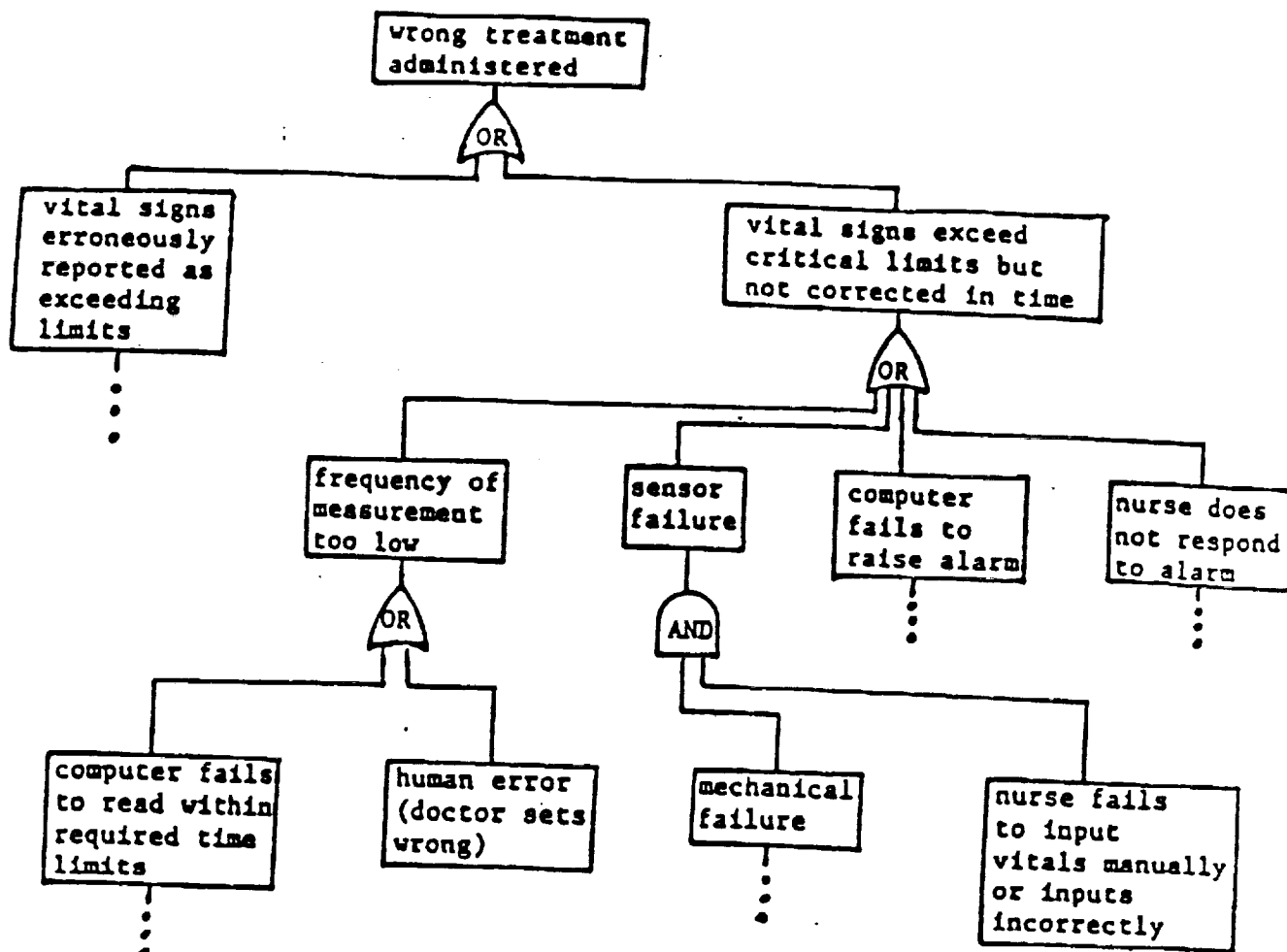


Figure 1. Top Levels of Patient Monitoring System Fault Tree

## PETRI NET MODELS

Have developed analysis procedures to:

- identify hazards and safety-critical single and multiple failure sequences
- determine software safety requirements including timing requirements
- analyze the design for safety and fault tolerance
- guide in the use of failure detection and recovery procedures

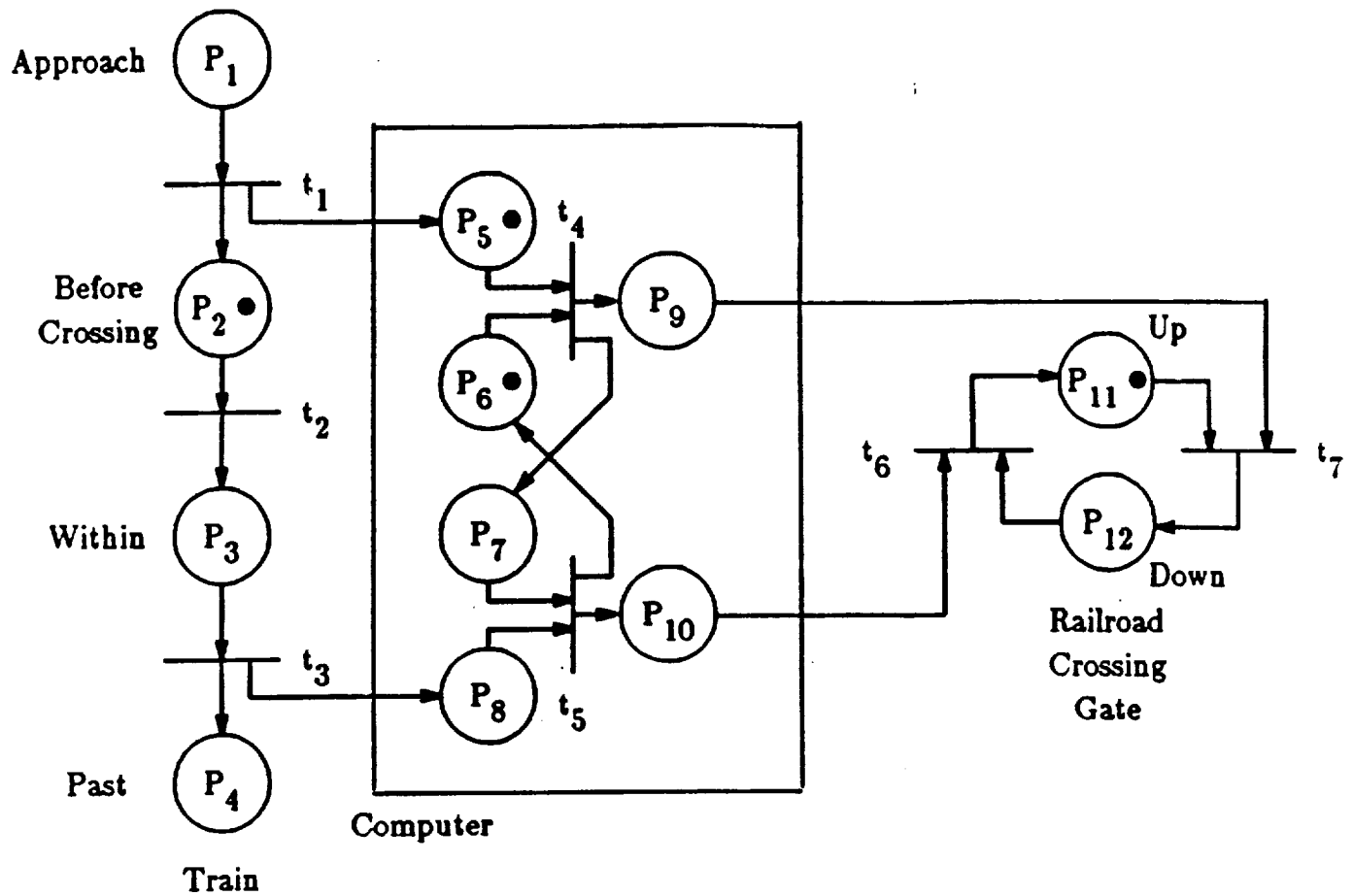


Figure 2. A Petri Net Graph with the Next State Shown

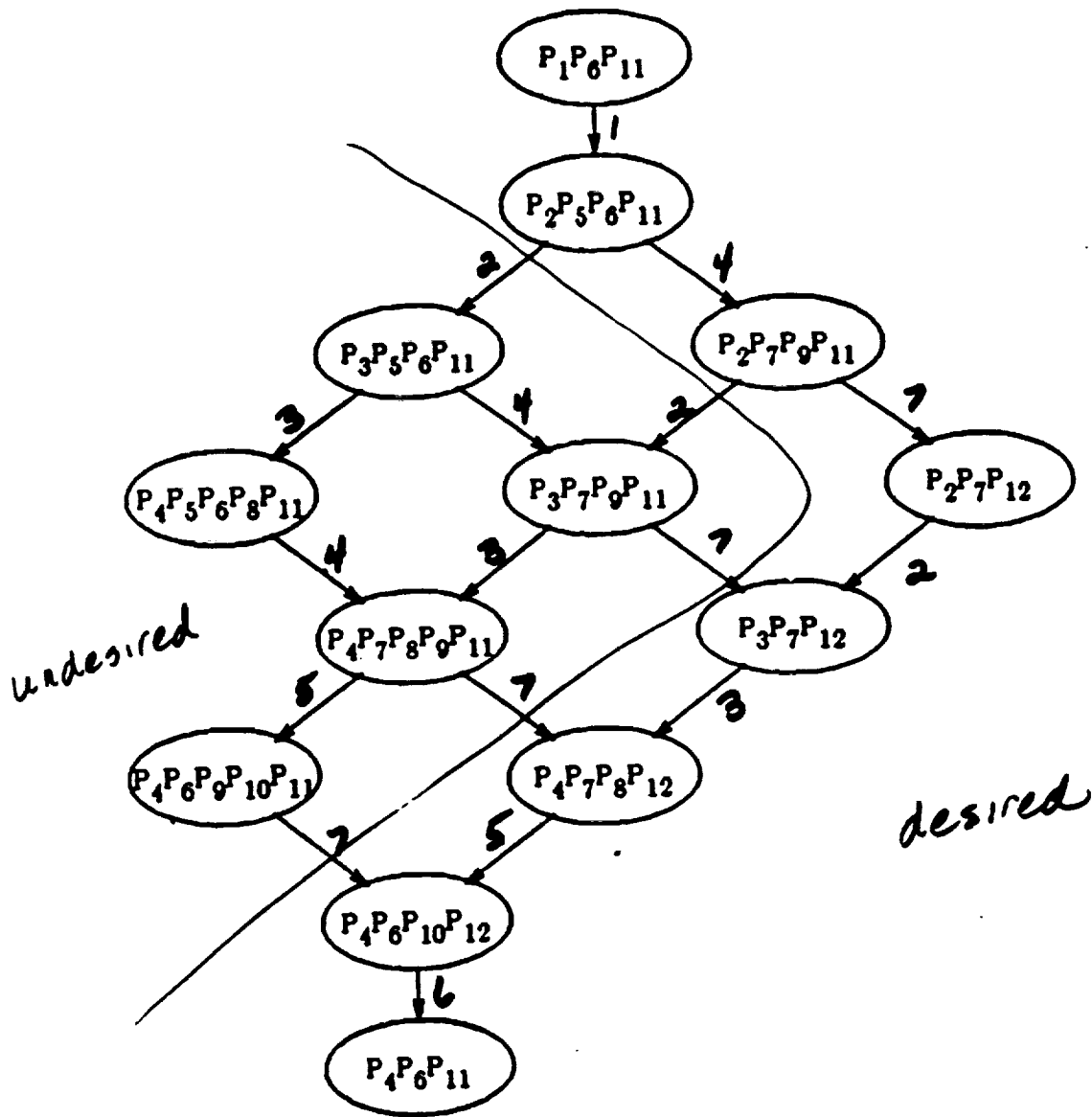


Figure 3. Reachability Graph for Figure 1

*critical state*: path to high-risk and possibly low-risk states as well as path to only low-risk states.

Algorithm:

Start with high-risk states. Generate those one step back and see if can go forward from them (Look forward one).

Work back to first potential critical state (state with two successors) and eliminate bad path.

- What if state not really reachable?
- What if not really a critical state?
- How do we know what states to start with. i.e. what about miscellaneous conditions?

**Modify design to disallow traversal of undesired path**

- **change design - e.g. add interlocks, lockouts, etc.**
- **add timing constraints**

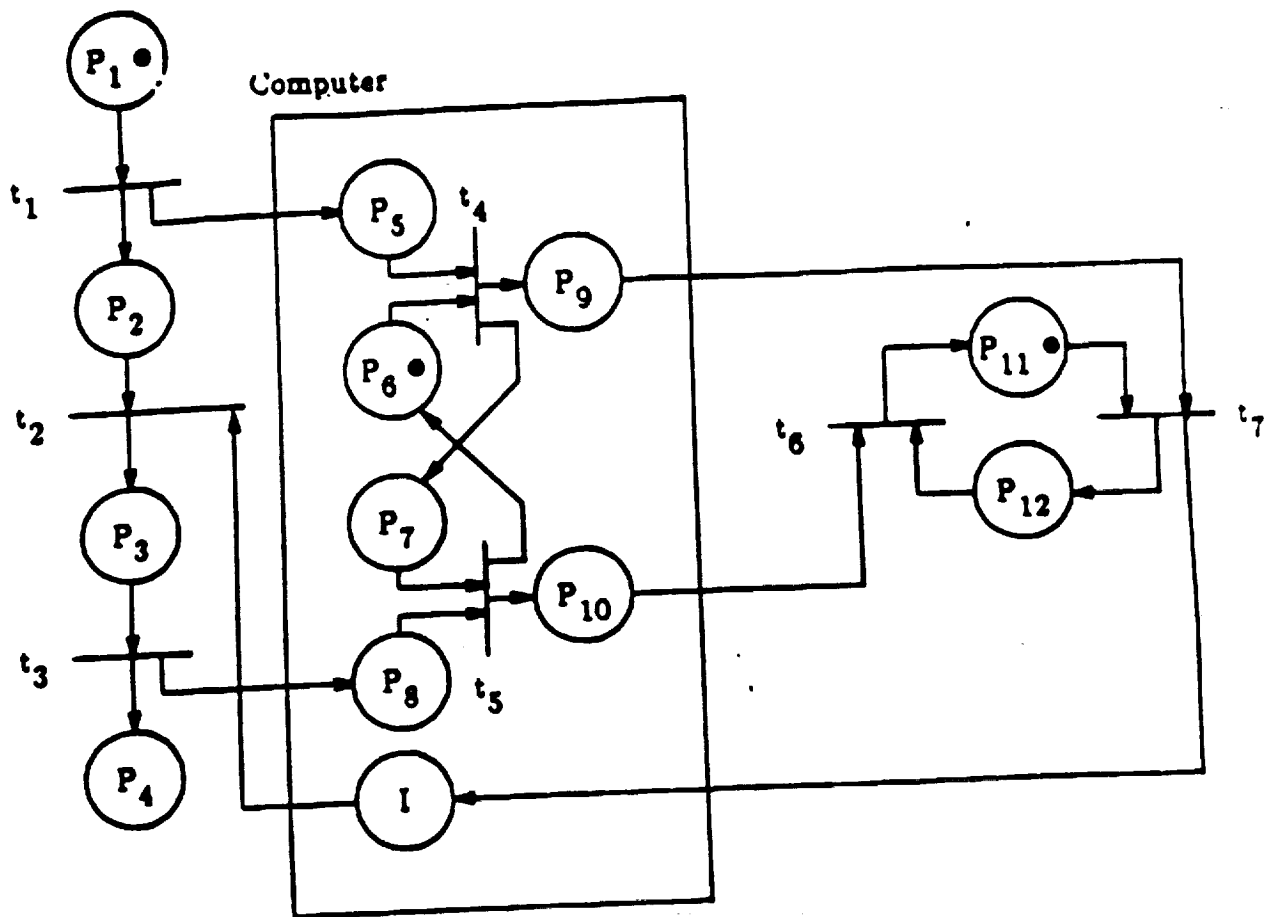


Figure 4c. A Petri Net Graph with an Interlock (I)

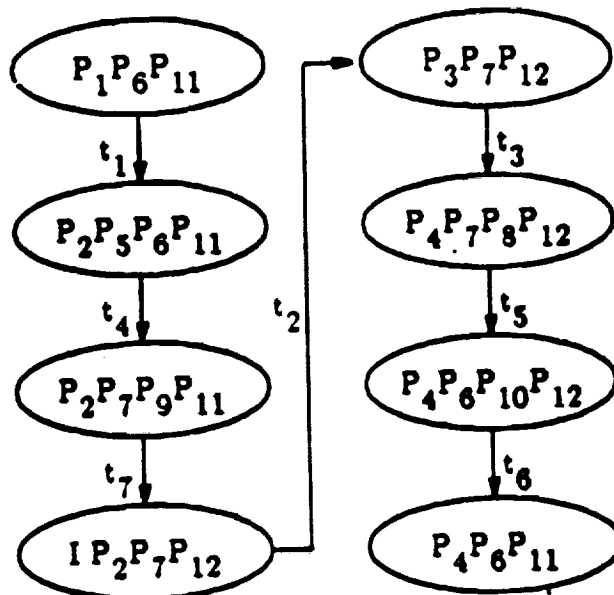


Figure 4d  
Reachability Graph for Figure 4c

## Time Petri Nets

Add two times to each transition:

minimum required enabling time

maximum time before transition must fire

Adding time makes analysis more difficult, but since interested in worst case behavior:

- 1) Derive non-time reachability graph
- 2) Then use this to determine timing requirements

## Adding Failures to the Analysis

Types of control failures:

- a required event that does not occur

- an undesired event

- an incorrect sequence of required events

- two incompatible events occurring simultaneously

- timing failures in event sequences

  - exceeding maximum time constraints between events

  - failing to ensure minimum time constraints between events

- durational failures

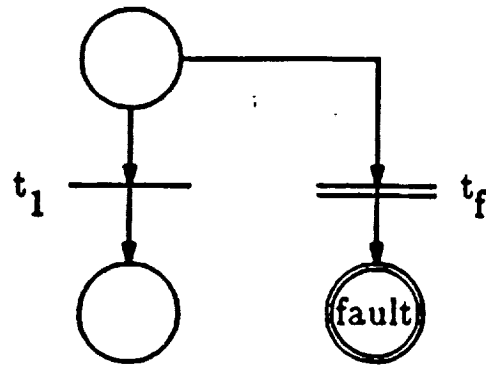


Figure 5a. Desired Event  $t_1$  Does Not Occur

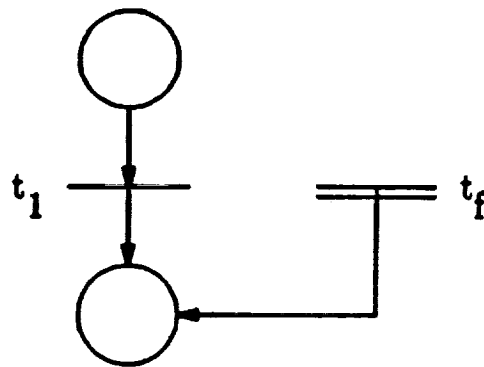


Figure 5b. Undesired Event  $t_1$  Occurs

**Important safety properties of a design:**

**Recoverable**

**Fault Tolerant**

**Fail Safe**

***faulty state:*** every path to it from the initial state contains a failure transition.

***Recoverable:*** after the occurrence of a failure, the control of the process is not lost, and in an acceptable amount of time, it will return to normal execution.

- 1) the number of faulty states is finite
- 2) there are no terminal faulty states
- 3) there are no directed loops containing only faulty states
- 4) the sum of the max times on all paths from the failure transition to a correct state is less than a predefined acceptable amount of time.

***correct behavior path:*** a path in the failure reachability graph from the initial state to a final state which contains no failure transitions.

***Fault Tolerant Process:***

- 1) a correct behavior path is a subsequence of every path from the initial state to any terminal state.
- 2) the sum of the maximum times on all paths is less than a pre-defined acceptable amount of time.

***Fail-Safe:*** all paths from a failure F contain only low-risk states.

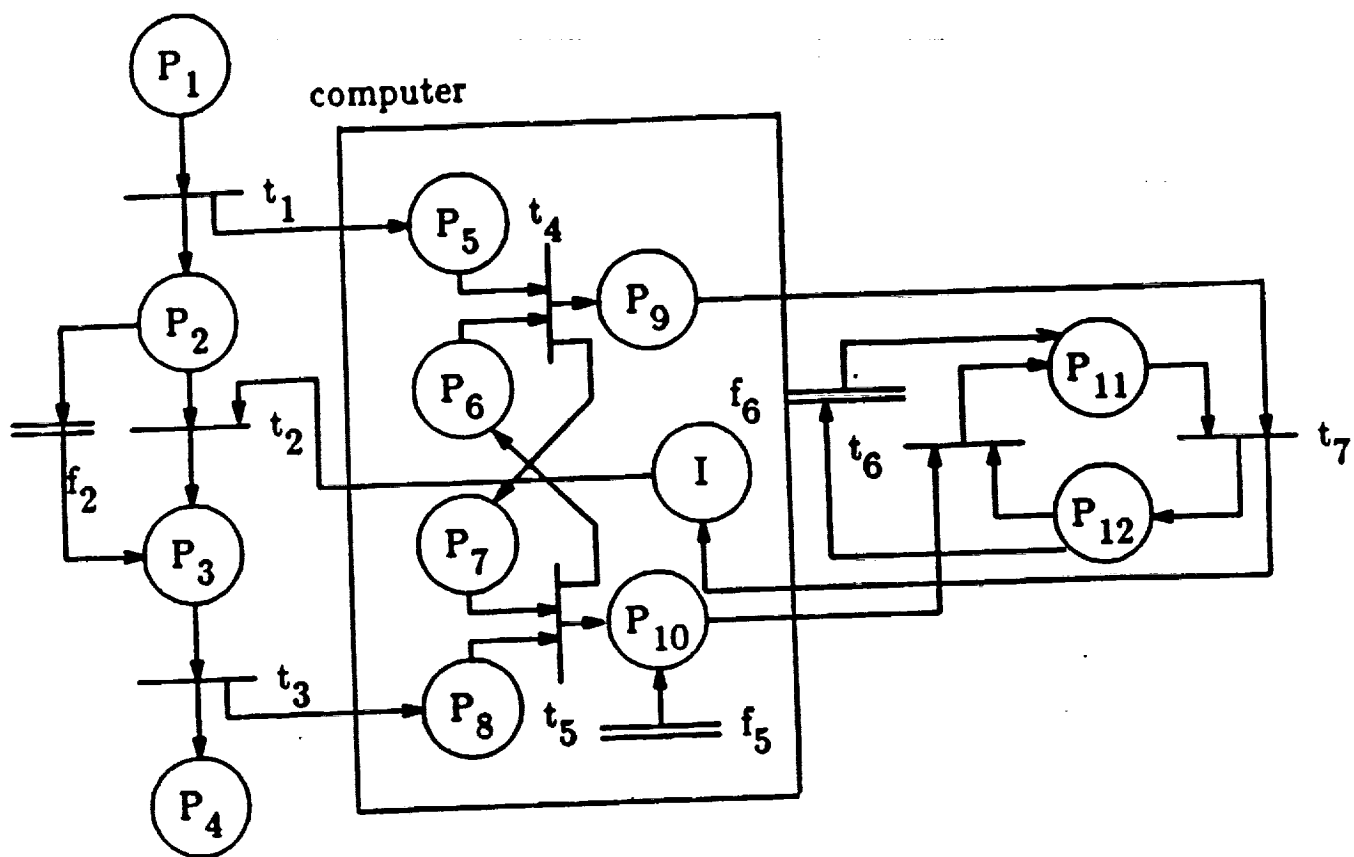


Figure 8a. A Petri Net Graph with Failures

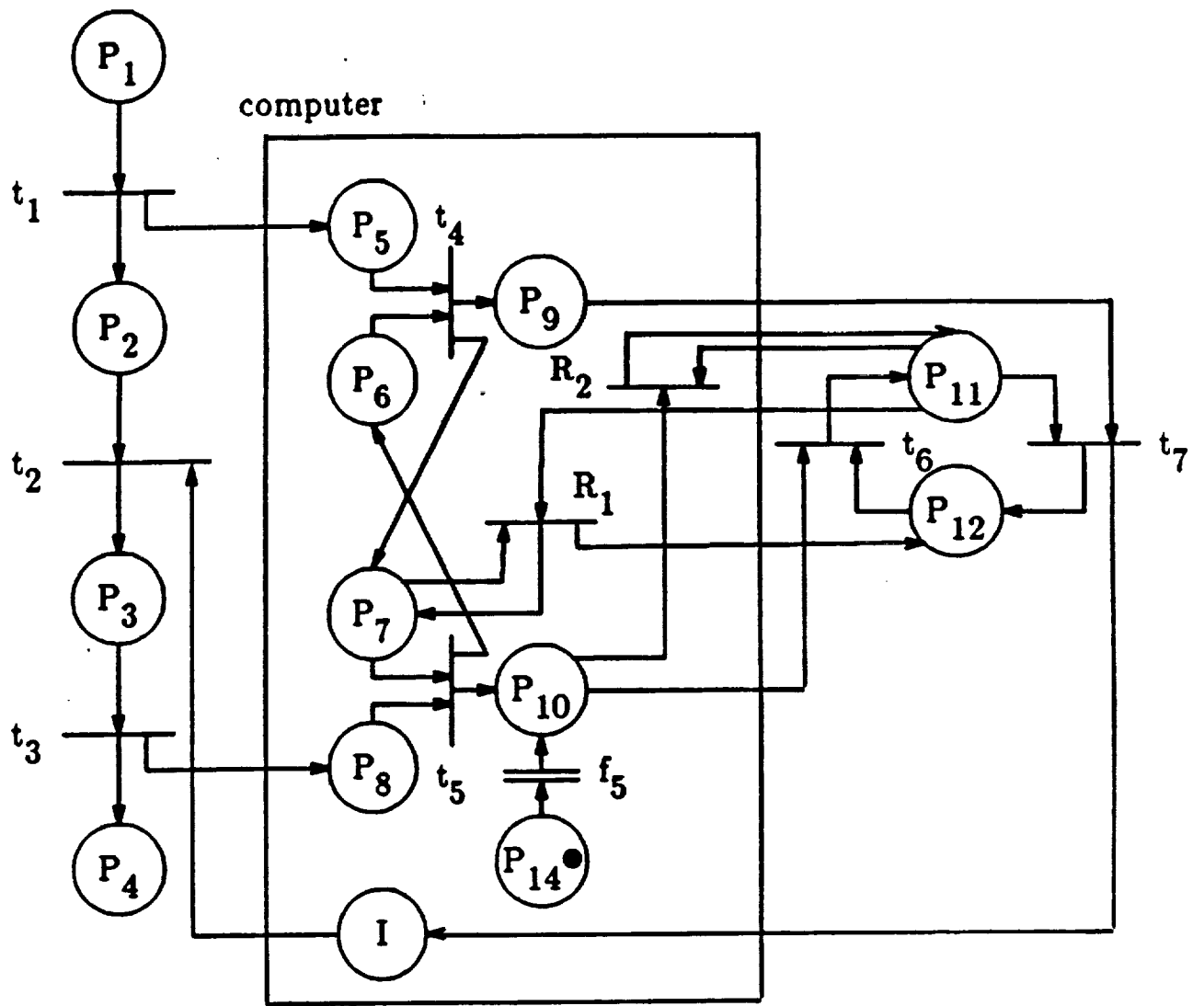


Figure 9. A Petri Net Graph with Failure Transition and Recovery

- Included in Mil-Std-882B (System Safety) and AF Handbook on Software Safety
- Used experimentally on some real projects
- Never meant to be practical — changing to a better model.

## External Interaction Model

Goal is to interface between system engineering and software engineering.

EIM includes the software behavior and assumptions about the behavior of the environment within which the software will operate.

Uses:

- To verify system correctness (software requirements satisfy system requirements) including satisfying constraints.
- To minimize effects of system requirements and design changes on software through appropriate design.
- To determine and specify appropriate responses by software to violations of environmental assumptions (robustness).

Cannot just “scale-up” techniques for specifying interface between software components.

Can use model to determine whether the components (including the software) of the larger system working together exhibit certain properties.

Partial responsibility for ensuring some properties may be assigned to software.

Their existence may be affected by behavior of software.

Static analysis of properties vs. dynamic control during execution

In both cases, must prepare system under development, systematically from the outset, to satisfy them.

Safety is an emergent or non-hierarchical property.

Appears only when system components considered as a whole not in individual components.

Accidents most often occur in the interfaces of systems — a consequence of undesired and unhandled interactions between components.

## Statecharts:

- extension of finite-state machines to include:
  - hierarchy
  - modularity
  - orthogonality
  - generalized transitions
- Provides graphical language with rigorous semantics.
- But doesn't have:
  - communication other than broadcast
  - straightforward notation for assigning attributes to inputs and outputs
  - probabilities
  - analysis techniques defined on it.

Use Statecharts to describe state information of all components and add:

1) Input and output exchange declarations

input exchange chart:

value(Y)  $\in$  ValuRange(Y)  
time(Y)  $\in$  TimeRange(Y)  
timetype(Y)  $\in$  {continual, periodic, S-R}  
source(Y)  $\in$  C  
capacity  
exceptions

output exchange chart:

value(X)  $\in$  ValuRange(X)  
time(X)  $\in$  TimeRange(X)  
timetype(X)  $\in$  {continual, periodic, S-R}  
destination(X)  $\in$  C  
load

## 2) Rules and mappings for these exchanges

Make explicit the assumptions and allowed interactions according to given, implied, and derived constraints.

Static checking for inconsistencies between matched exchanges

Source for dynamic checking of inconsistencies between real state of environment and computer model of it.

As external state changes, inputs provide current status and feedback information to update internal model.

Two types of safety analysis defined on EIM model:

- Safety analysis assuming no failures — provide confidence that if system performs as specified, will not reach a hazardous state.

backwards reachability analysis based on  
critical states

- Analysis with failure — fault tree analysis generated directly from model's state representation.

Determine erroneous software states that can  
lead to system hazards.

## TESTBED:

### TCAS II: Traffic Alert and Collision Avoidance System

- Family of airborne devices functioning independently of the ground-based ATC system.
- Provides traffic advisories to assist pilot in avoiding intruder aircraft.
- Provides resolution advisories (recommended escape maneuvers) in a vertical direction to avoid conflicting traffic.
- Communicates with intruder aircraft TCAS systems, transponders on intruder aircraft, pilot, and ground-based radar beacon system.
- Used by airline aircraft and larger commuter and business aircraft.
- We will provide a system requirements specification and a safety analysis of the specification.

## ESTABLISHING SOFTWARE SAFETY REQUIREMENTS

Goal: Rewriting software hazards identified by the SHA as software requirements

Need to consider:

- what system *shall not* do
- means for eliminating and controlling damage in case of an accident
- ways in which software can fail safely and to what extent failure is tolerable.

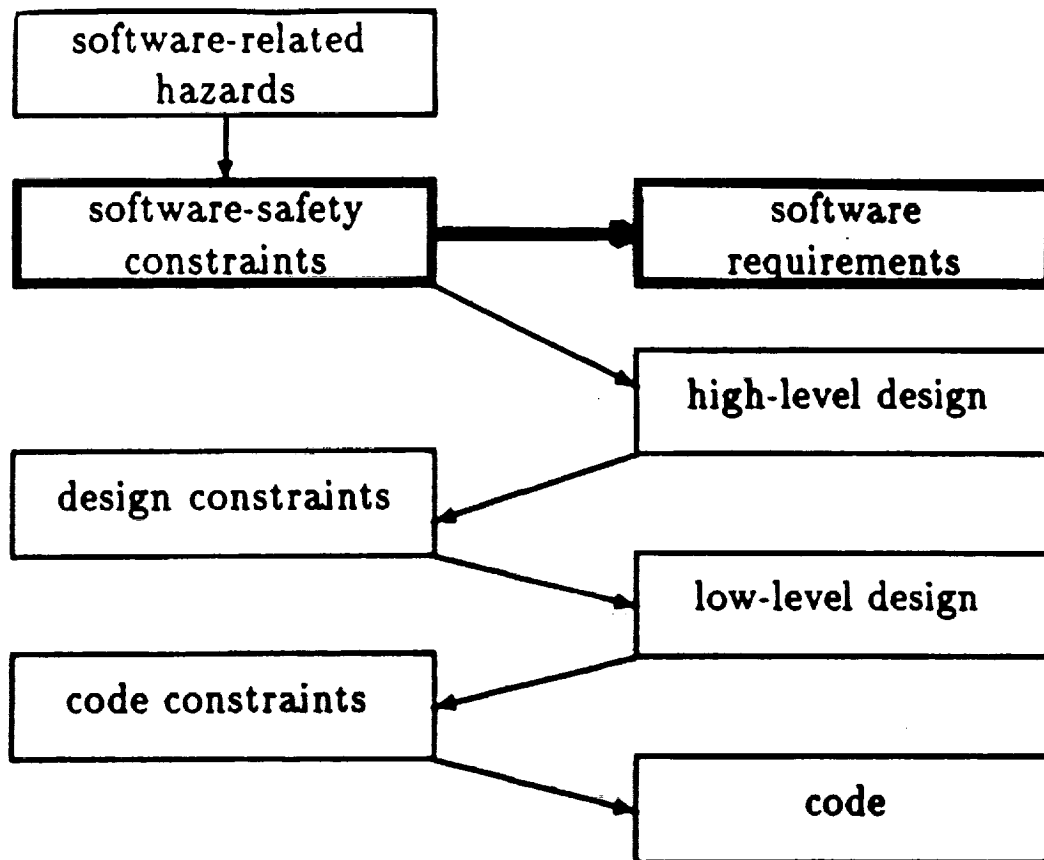
## **SOFTWARE SAFETY REQUIREMENTS REVIEW**

**Goal:** identify critical requirements, missing requirements, requirements that may conflict with safety.

**Participants:** software engineers  
                  system engineers  
                  application engineers  
                  safety engineers

**Results used to:** improve software requirements specification  
                      update Software Hazards List  
                      update detailed safety design criteria  
                      test and evaluation criteria

**Techniques:** Ad hoc techniques  
                  Real Time Logic



### **Requirements Analysis:**

- **Analyze software requirements for robustness, lack of ambiguity, consistency with system requirements**
- **Verify consistency with safety constraints.**
- **Identify conflicts and tradeoffs.**

## What is Correctness?

A system is a set of component working together to achieve some common objective or function.

Three components of system requirements:

1) Basic function or objective

2) Constraints on operating conditions

Define range of conditions within which system may operate while achieving its objective.

Limit the set of acceptable designs.

Arise from several sources:

- quality considerations
- physical limitations on equipment
- process characteristics
- safety considerations

3) Prioritized quality goals to:

Judge which alternative design is best

Resolve tradeoffs between conflicting requirements.

Two aspects of specification correctness:

- Implementation correctness

Constructed component satisfies its requirements specification.

Specification must distinguish behavior of desired software from any other, undesired program that might be designed.

Requires specification to be sufficiently unambiguous.

- System correctness

Component behavior, if implementation satisfies its requirements, together with specified behavior of the other components will satisfy the system requirements.

Approaches to finding errors in requirements specifications:

- Prototyping
- Executable specifications
- Scenarios
- Informal reviews
- Formal modeling and analysis

Build model of software behavior and its interface with other components and analyze to ensure behavior and properties of model match desired behavior and properties.

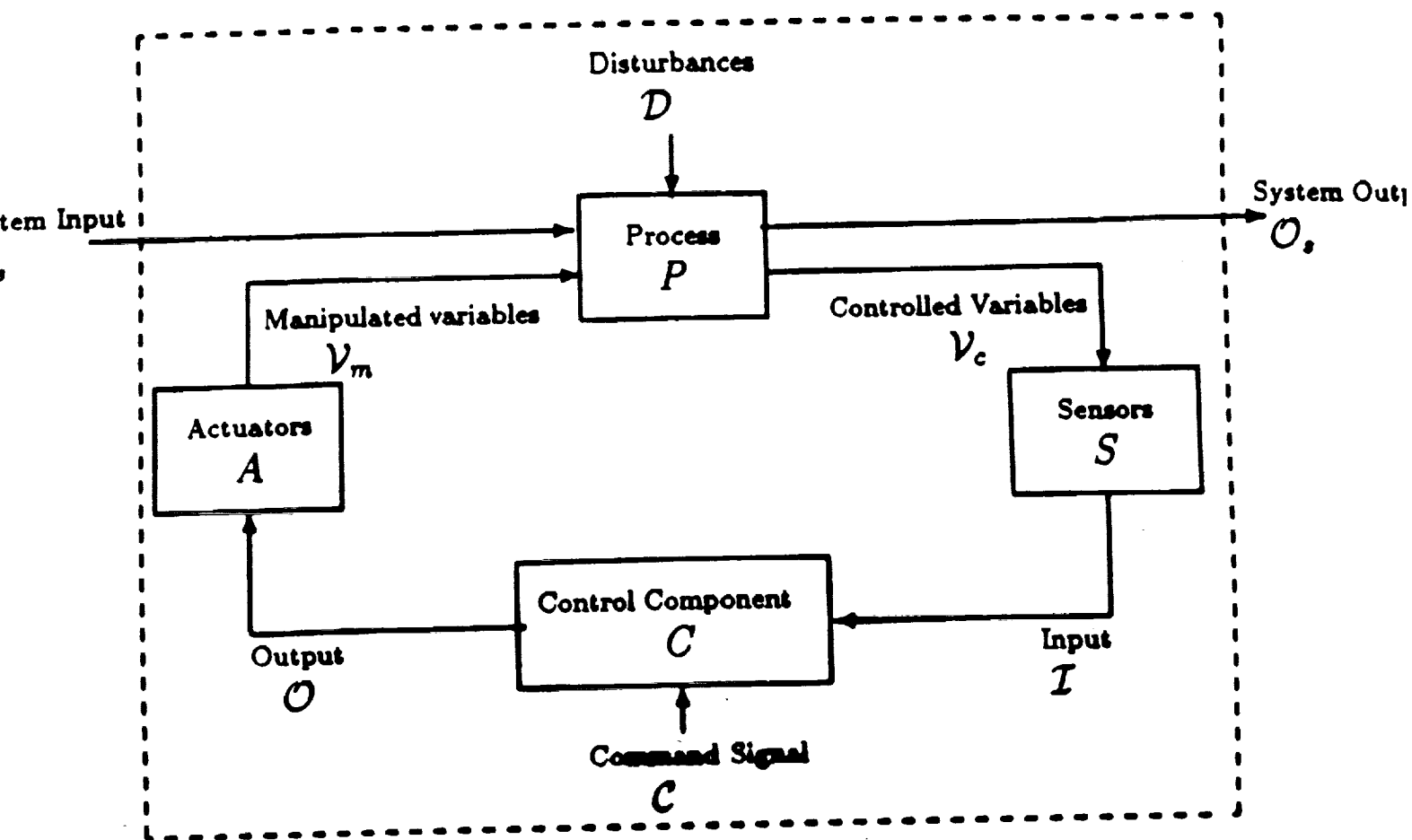


Figure 1: The control loop

The RSM is denoted as a seven-tuple  $(\Sigma, Q, q_0, P_T, P_O, \delta, \gamma)$  where:

- $\Sigma$  is the set of input/output variables,  $\mathcal{I}$  and  $\mathcal{O}$ ,
- $Q$  is the set of states of the control component  $C$ .
- $q_0 \in Q$  is the initial state of  $C$ ; the software is in this state before startup.
- $P_T$  is the set predicates on the values and timing of the inputs ( $\mathcal{I}$ ). They trigger state change in the RSM.
- $P_O$  is the set of predicates on the outputs ( $\mathcal{O}$ )
- $\delta$  is the state transition function  $Q \times P_T$  to  $Q$ .
- (  $\gamma$  is the trigger-to-output relationship  $Q \times P_T$  to  $P_O$ .

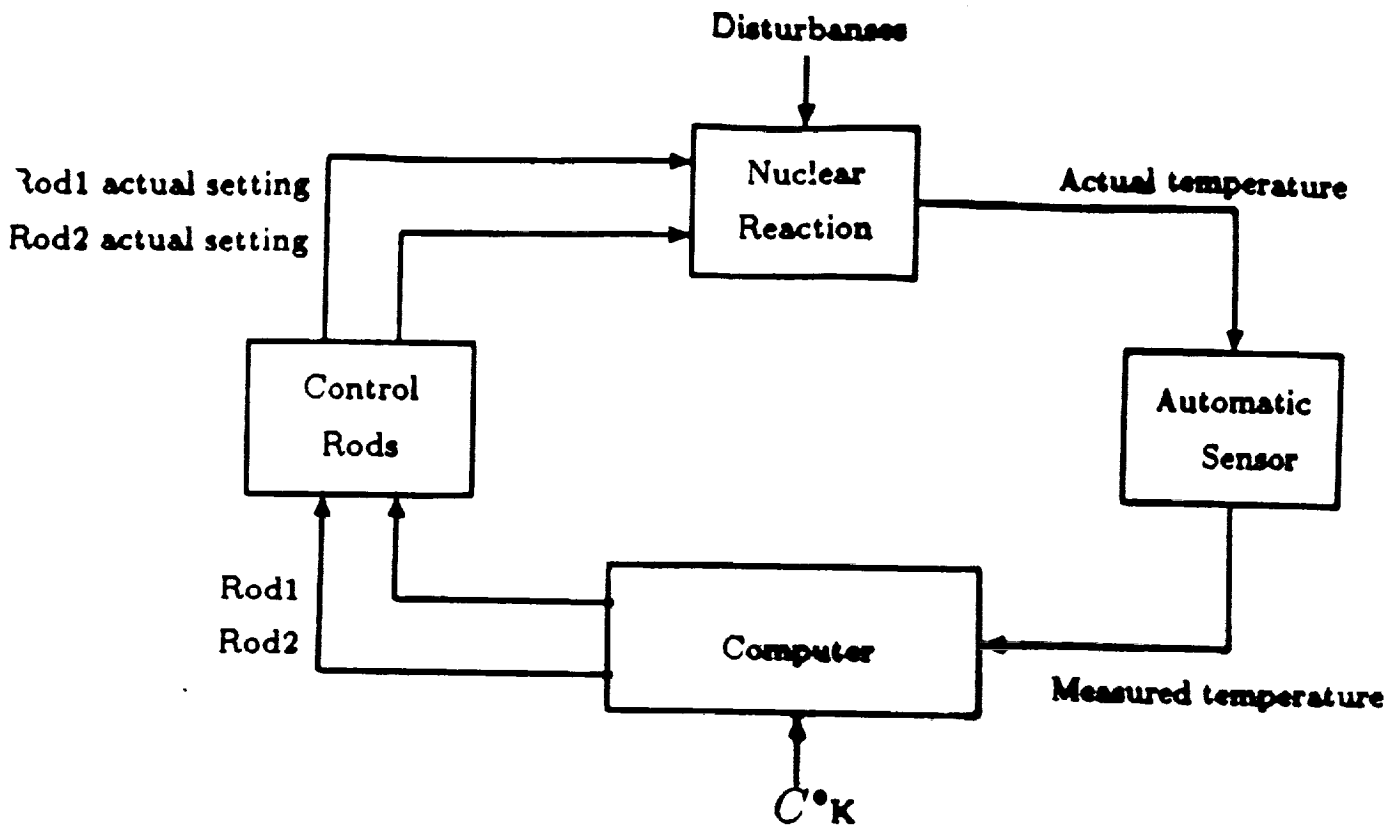


Figure 2: Block diagram of the temperature control system.

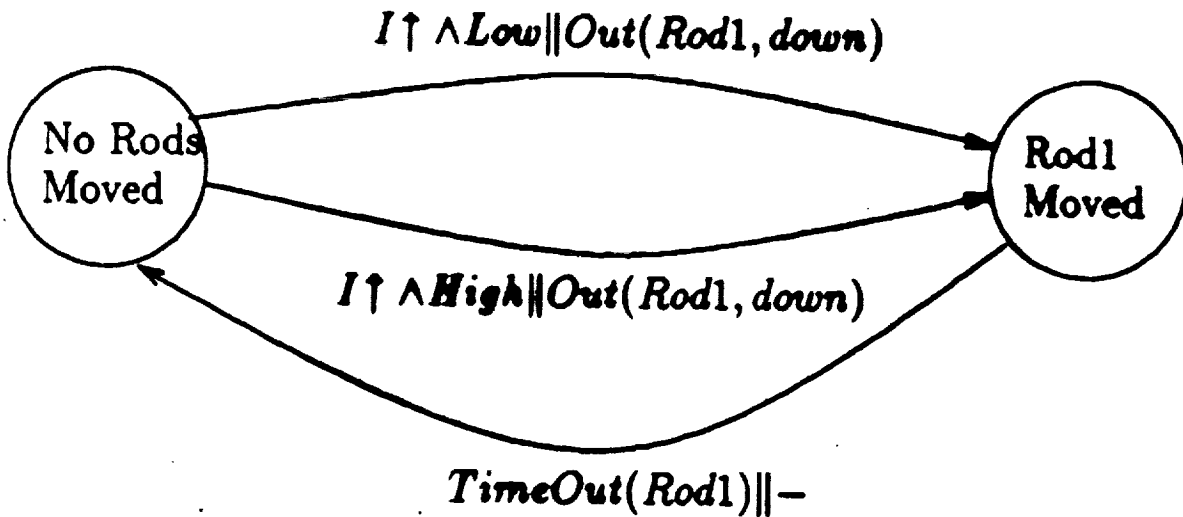


Figure 3: A fragment of an RSM

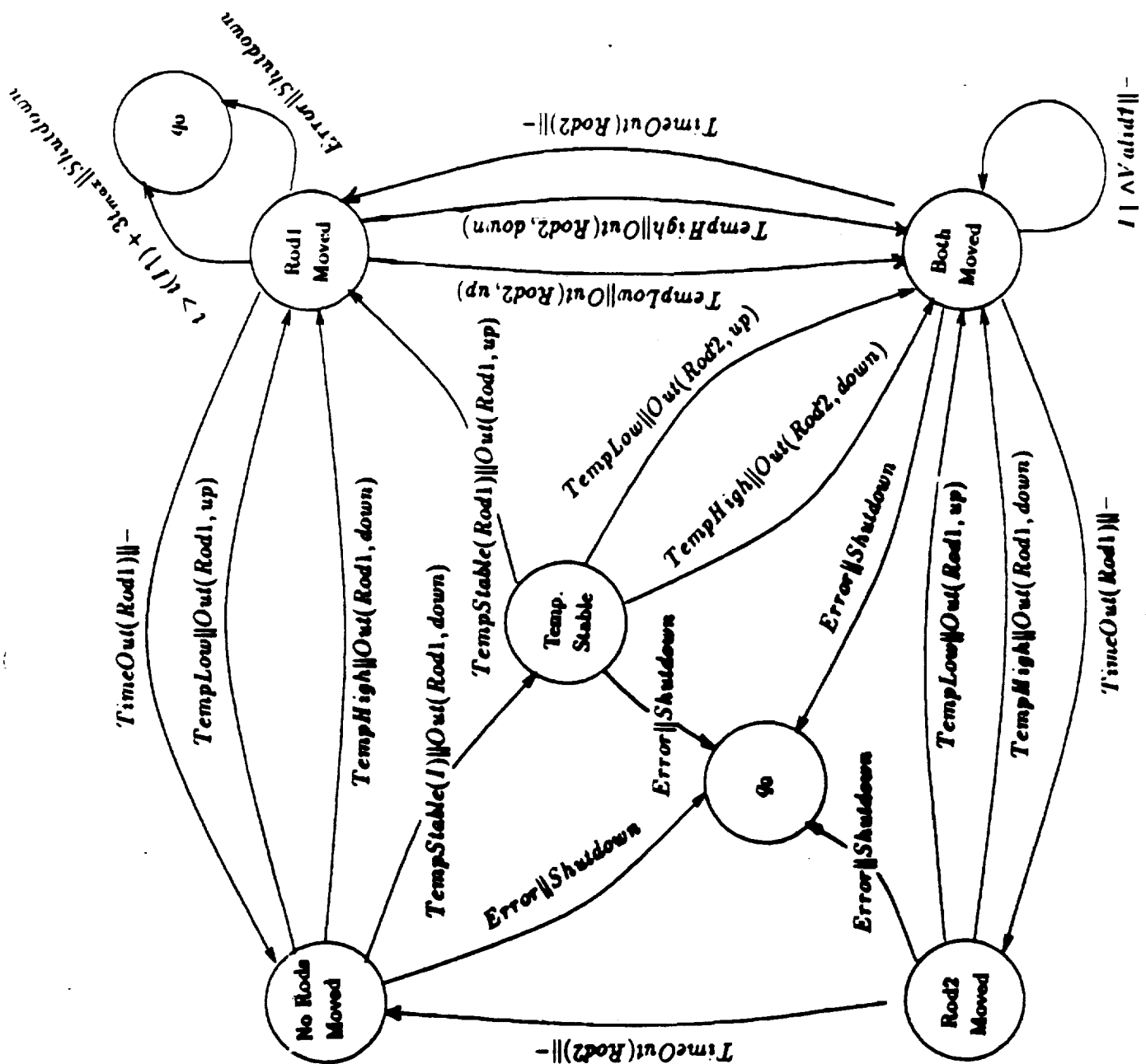
$$Low = v(I) < C^{\circ}K$$

$$High = v(I) \geq C^{\circ}K$$

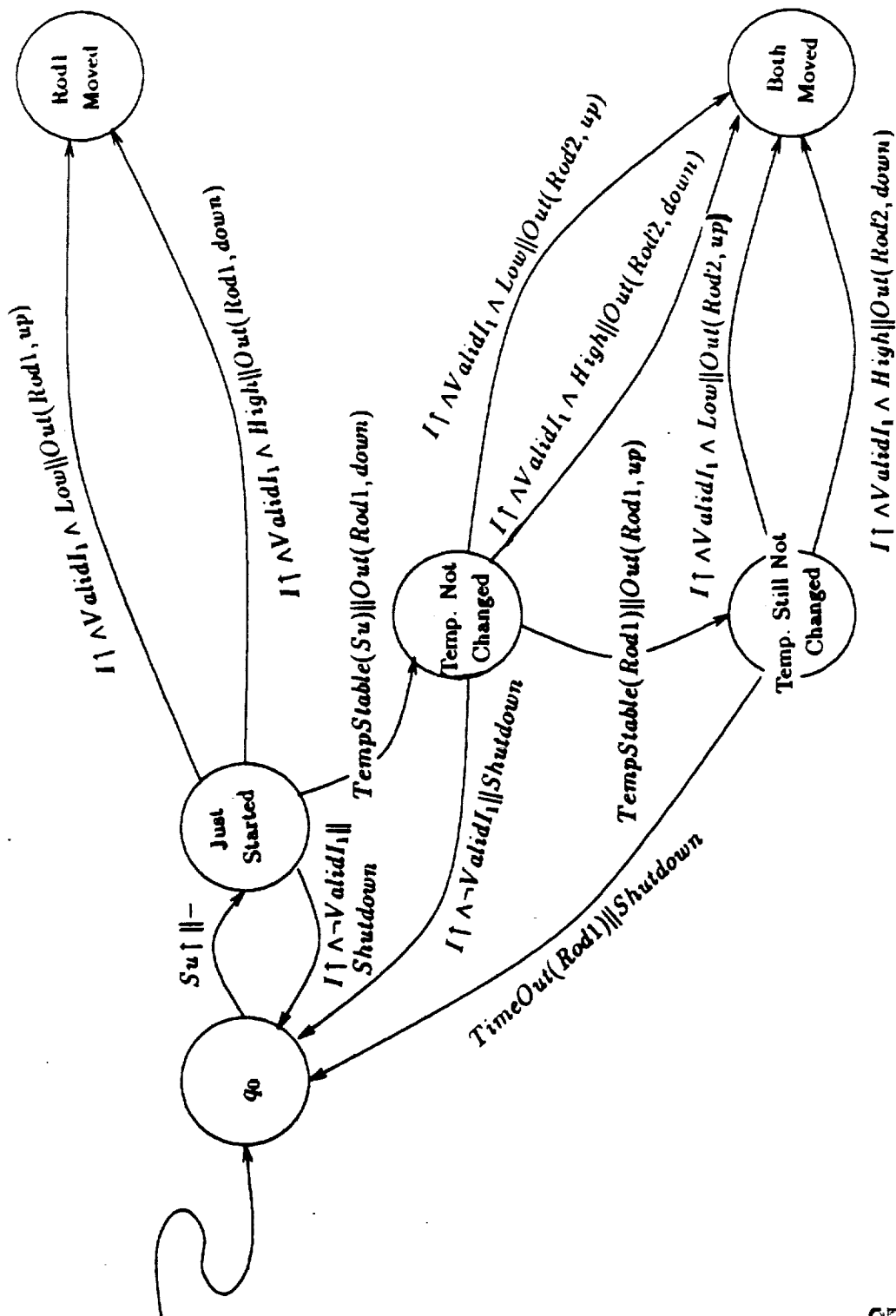
$$TimeOut(x) = t > t(x \uparrow) + 30$$

$$Out(O, x) = O \uparrow \wedge (v(O) = x)$$

# Normal Operation.



# The Startup Sequence.



*(Criteria + heuristics)*

- Input/output Variables  $\Sigma$
- States  $Q, q_0$

Startup and Shutdown  
Modes

- Trigger Predicates  $P_T$

Tautology Requirements  
Essential Value Assumptions  
Essential Timing Assumptions  
Properly bounded ranges  
Capacity and load  
Minimum arrival rates, etc.

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**Criterion 6.1** Every state must have a behavior (transition) defined for every possible input. Formally,

$$\forall I, q \exists q_1, p : (\delta(q, p) = q_1) \wedge (p \in P_{T_I})$$

where  $I \in \Sigma$ ,  $q, q_1 \in Q$  and  $P_{T_I}$  is defined as in section 4.

**Criterion 6.2** The logical OR ( $\vee$ ) of the input predicates on the transitions out of any state must form a tautology:

$$\models \bigvee_i p_i$$

where the  $p_i$ s are the input predicates leading out of the state of interest.

**Criterion 6.3** Every state must have a behavior (transition) defined in case there is *no* input for a given period of time, i.e., a timeout.

**Criterion 6.4** The RSM must to be deterministic. Let  $p_i$  represent the input predicate on the  $i$ th transition out of a state. Then deterministic behavior is guaranteed by:

$$\forall i \forall j (i \neq j) \Rightarrow \neg(p_i \wedge p_j)$$

- Output Predicates  $P_o$

Environmental capacity considerations

Data Age

Latency

- Trigger-to-Output Relationship  $\gamma$

Graceful Degradation

Hysteresis

Responsiveness and Spontaneity (Feedback)

- **Transitions**  $\delta$

**Basic Reachability**

**Recurrent Behavior**

**Reversibility**

**Reachability of Safe States**

**Path Robustness**

**Constraint Analysis**

**Criterion 9.3** Reversibility of an operation  $x$  (performed in a state  $q_x$ ) by an operation  $y$  (performed in a state  $q \in Q_y$ ) requires a path between  $q_x$  and a state belonging to  $Q_y$ . Formally,

$$\exists q \exists s : (\hat{\delta}(q_x, s) = q) \wedge (\phi(s_i)).$$

where  $q \in Q_y$ .

### **PATH ROBUSTNESS**

**Criterion 9.5** Soft and hard-failure modes should be eliminated for all hazard-reducing outputs. Formally, let  $Q_x$  and  $Q_y$  be the sets of states where actions  $x$  and  $y$  are performed. The loss of the ability to receive  $I$  is a soft-failure mode for the paths from action  $x$  to action  $y$  iff

$$\exists q \forall q_1, s [(\hat{\delta}(q, s) = q_1) \Rightarrow (\neg \phi(s_i) \vee I \uparrow)]$$

where  $q \in Q_x$  and  $q_1 \in Q_y$ .

The loss of the ability to receive  $I$  is a hard-failure mode iff

$$\forall q \forall q_1, s [(\hat{\delta}(q, s) = q_1) \Rightarrow (\neg \phi(s_i) \vee I \uparrow)]$$

where  $q \in Q_x$  and  $q_1 \in Q_y$ .

### Future Goals:

- Extend criteria on RSM
- Define analysis procedures for the criteria
- Demonstrate by applying to TCAS

*Transactions on Software Engineering*, March 1991.

## SAFE SOFTWARE DESIGN PRINCIPLES

- Preventing Hazards
- Detecting and Recovering from Hazards
- Example

## **SOFTWARE SAFETY DESIGN CONCEPTS**

**Analysis and verification alone not enough because:**

- **techniques are error-prone**
- **cost may be prohibitive**
- **elimination of all hazards may require too severe a performance penalty**

**Two general principles:**

- (1) design should provide leverage for certification effort**
- (2) avoid ~~adding~~ adding complexity**

**Two categories:**

- **Prevention of hazards through software design**  
**(tends to involve reduction of functionality or design freedom)**
- **Detection and treatment at run-time**  
**(difficult and unreliable)**

## PREVENTING HAZARDS THROUGH SOFTWARE DESIGN

General goals: make software intrinsically safe so that software faults and failures cannot lead to system hazards.

General approach: reduce amount of software that affects safety and change as many potentially critical faults into non-critical faults as possible.

- Design to limit actions of software
  - modularization
  - data access limitations
  - separate critical from non-critical functions
  - firewalls
  - hierarchical design
- Authority limitation to protect critical functions and data
- Minimize hazardous states or time in them
- Use software interlocks to ensure sequencing or prevent hazardous outputs
- Protect against hardware failures

## DETECTION AND TREATMENT AT RUN-TIME

### *Detection:*

assertions  
acceptance tests  
external monitors  
watchdog timers  
voting

- Mechanisms not as much of a problem as formulating the checks

### ***Recovery:***

- **Safety recovery routines needed when:**
  - unsafe state detected externally**
  - determined that software cannot provide required output within a prescribed time limit**
  - continuation of regular routine would lead to a hazard if no intervention**
- **Backward adequate if can be guaranteed that software faults will be detected and successful recovery completed before fault affect external state.**
- **Forward recovery usually also needed**
  - robust data structures**
  - dynamic alteration of flow of control**
  - reconfiguration**
  - ignoring single cycle errors**
  - reduced function or fail-safe modes**
- **Design for a safe-side**

## **Fail-Safe Design**

**Design system to have a safe-side: state that is always reachable from any other state and that is always safe.**

- **Often has performance penalties.**
- **Besides shutting down, may need to take some action to avoid harm.**
- **Safety system itself may cause harm.**
- **May be intermediate safe states with limited functionality, especially in systems where shutdown itself would be hazardous.**
- **Reconfiguration or dynamic alteration of control is a form of partial shutdown.**

2 level structure:

## TOP LEVEL

- less important governing functions
- supervisory, coordination, management functions
- separate processor
- loss cannot endanger turbine nor cause it to shutdown

## BASE LEVEL

- secure software core that can detect significant failures of hardware

- self checks of:

- sensitivity of incoming signals
  - whether processor functioning correctly

- failure of self-check leads to reversion to safe state through fail-safe hardware.

No interrupts except for fatal store fault (nonmaskable)

- timing and sequencing defined
- more rigorous and exhaustive testing

Uses polling

- all messages unidirectional
- no recovery or contention protocols required
- higher level of predictability

State table defines:

scheduling of tasks

self-check criteria appropriate under particular conditions

## SOFTWARE DESIGN AND RECOVERY ANALYSIS

Two goals:

- (1) Identify safety-critical items.
- (2) Identify self-test, fault-tolerance, and fail-safe facilities needed for safety-critical items.

### ***Safety-Critical Items:***

- software processes, data items, or states whose inadvertent occurrence, failure to occur when required, occurrence out of sequence, occurrence in combination with other functions, or erroneous value can be involved in development of a hazard.
- Includes erroneous program states and data items that could cause a hazard even if function or algorithm is correct.
- Identify through backward flow analysis on top-level design to locate critical paths and data.

manual procedures

Software Fault Tree Analysis

Uses Hierarchy

- Used for:

feedback to software and system design

e.g. minimizing critical items

isolating critical items

designing fault tolerance facilities

planning load shedding and reconfiguration

### ***Recovery Analysis***

- Evaluate software and hardware failures for potential effect on safety-critical items.
- identify self-test, fault-tolerance, and fail-safe facilities needed for critical items.

### **Results:**

- Identification of assumptions about failures and undesired events
- Fault-tolerance and fail-safe guidelines for rest of software development
- Evaluation of safety design requirements
- Description of planned safety aspects of the design including prevention, detection, and treatment of hazards.
- Evaluation of planned safety aspects of design including fault detection and recovery facilities planned for each critical item.

## **SOFTWARE SAFETY DESIGN REVIEW**

**As part of regular design review:**

- (1) verify that safety requirements implemented in detailed design**
- (2) verify that software safety design criteria and fault tolerance guidelines implemented in design**
- (3) produce a final safety test recommendations report.**

## VERIFICATION OF SAFETY

- What is it?
- Software Fault Tree Analysis

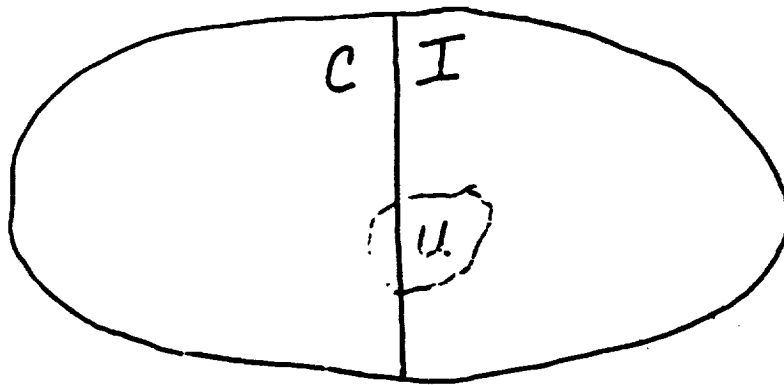
## CODE VERIFICATION AND VALIDATION

- If rest of program followed, need for most costly procedures will be minimized.
- Walkthroughs and formal verification (e.g. Software Fault Tree Analysis) needed only on modules determined to be so critical that testing or other assurance procedures alone will not suffice to ensure acceptable risk.
- Need to verify that detailed feature related to safety-critical items and fault-tolerance facilities have been correctly implemented.
- Need to verify that assumptions and models upon which analyses have been based are correct.

verification of correctness

vs.

verification of safety



## Software Fault Tree Analysis

- A symbolic logic diagram which shows cause and effect relationship (AND or OR) between an undesired event and one or more contributory causes.
- A Systems Tool
- Related to formal axiomatic program verification BUT:
  - specification derived from system requirements
  - include consideration of hardware failures, environmental conditions, human errors
  - proof by contradiction

(1)  $A := F(Y)$ ; (2)  $B := X - 5.0$ ; (3) if  $A > B$  then Sub1; end if;

Figure 8: Sample Assignment Statements

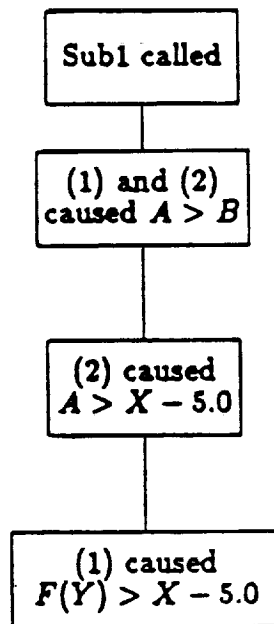


Figure 9: Fault Tree for Assignment Statements

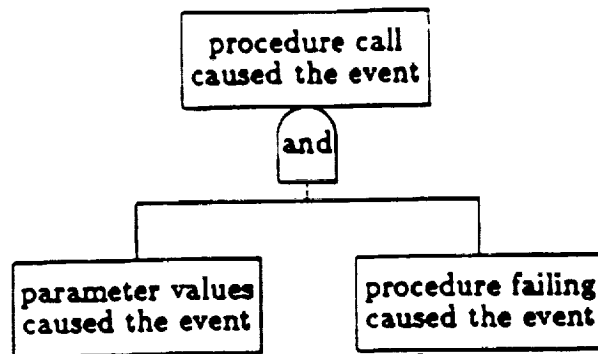


Figure 10: Fault Tree for a Procedure Call

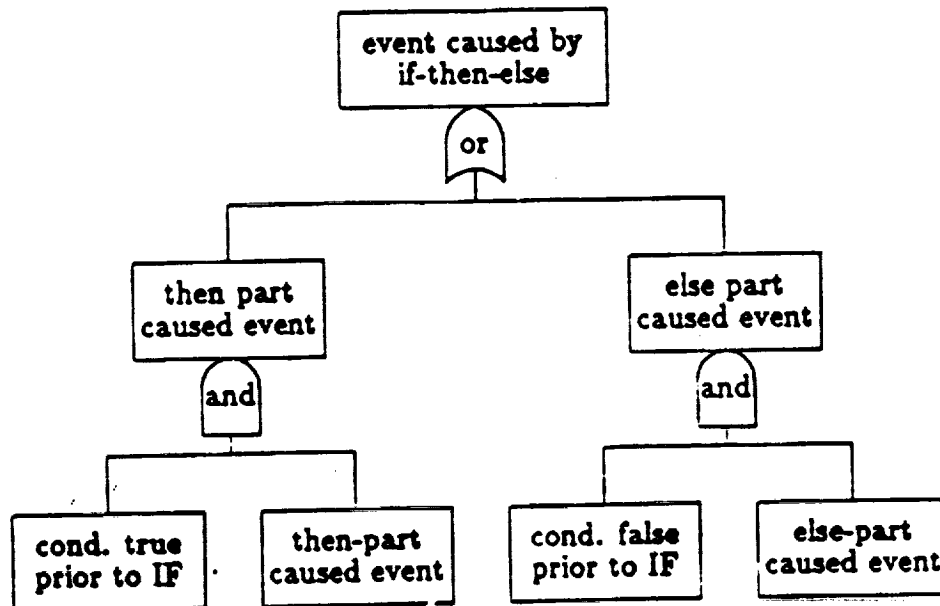


Figure 11: Fault Tree for an If-Then-Else Statement

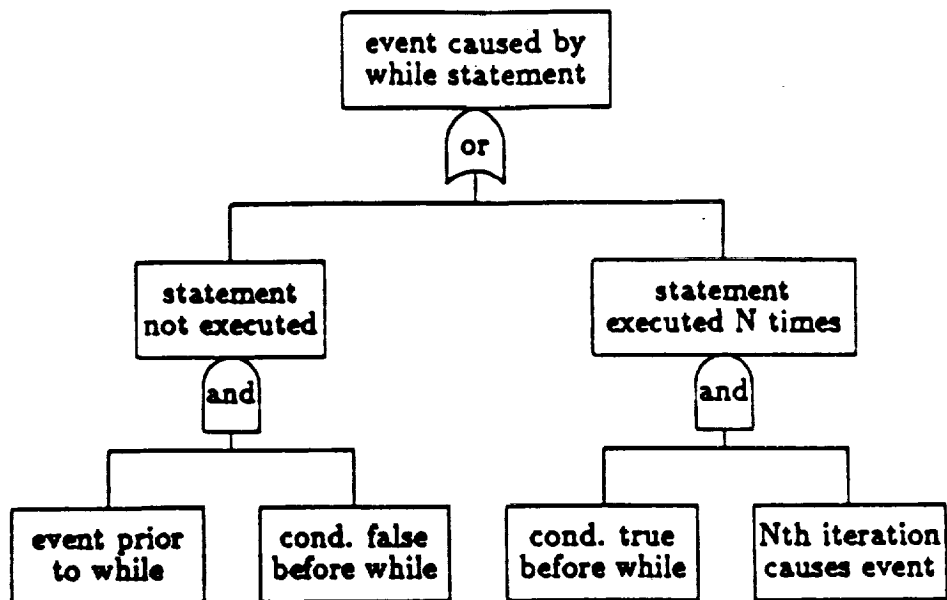


Figure 12: Fault Tree for a While Statement

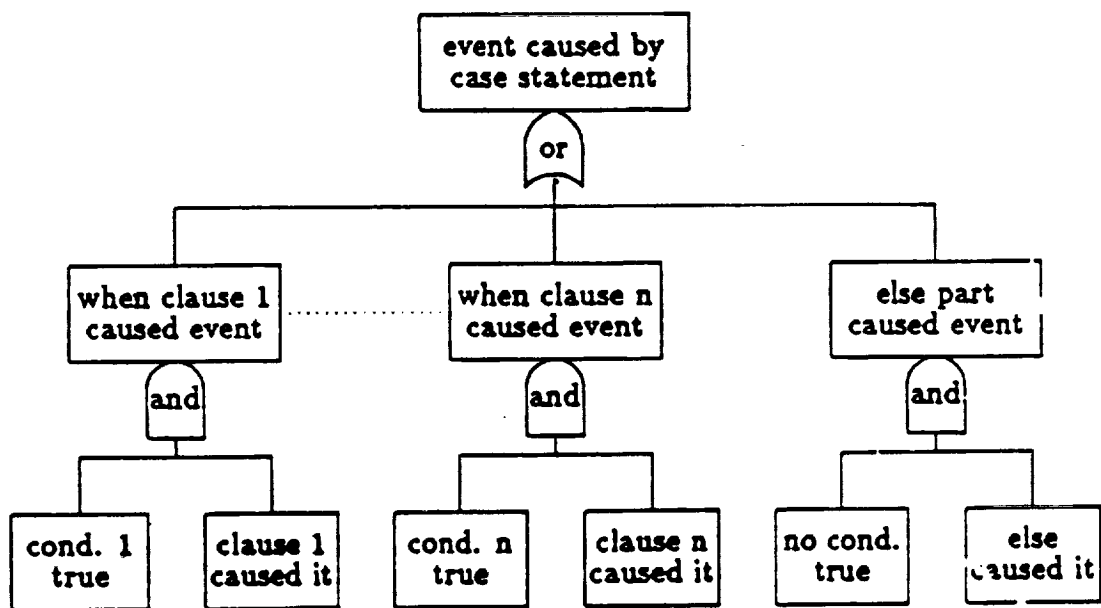


Figure 13: Fault Tree for a Case Statement

Software fault tree has two possible patterns:

- (1) A contradiction is found.
- (2) Fault tree runs through code and out to controlled system or its environment.

## FIREWHEEL Example

Used SFTA to analyze the flight and telemetry program for a U.C. Berkeley spacecraft.

- **Mission:** to sample electric fields in the earth's magnetotail.
- **Critical Failure Event:** ripping wire booms off spacecraft.
- **Cost:** needed to examine 12% of code (out of approximately 300 lines of Pascal code), took two man days
- **Results:** A critical scenario detected that was undiscovered during a thorough test and evaluation by an independent group.

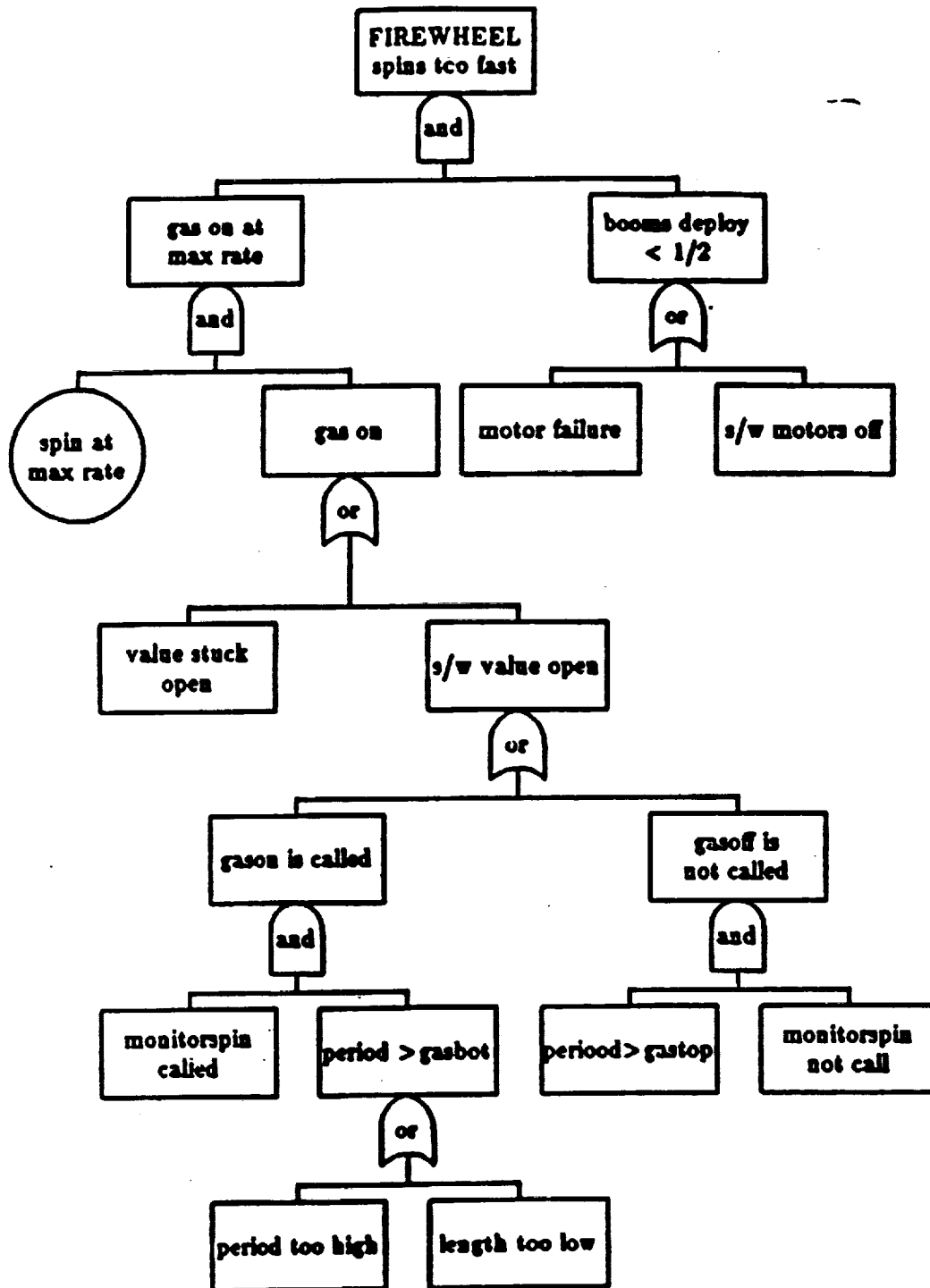
# PETER HARVEY

1

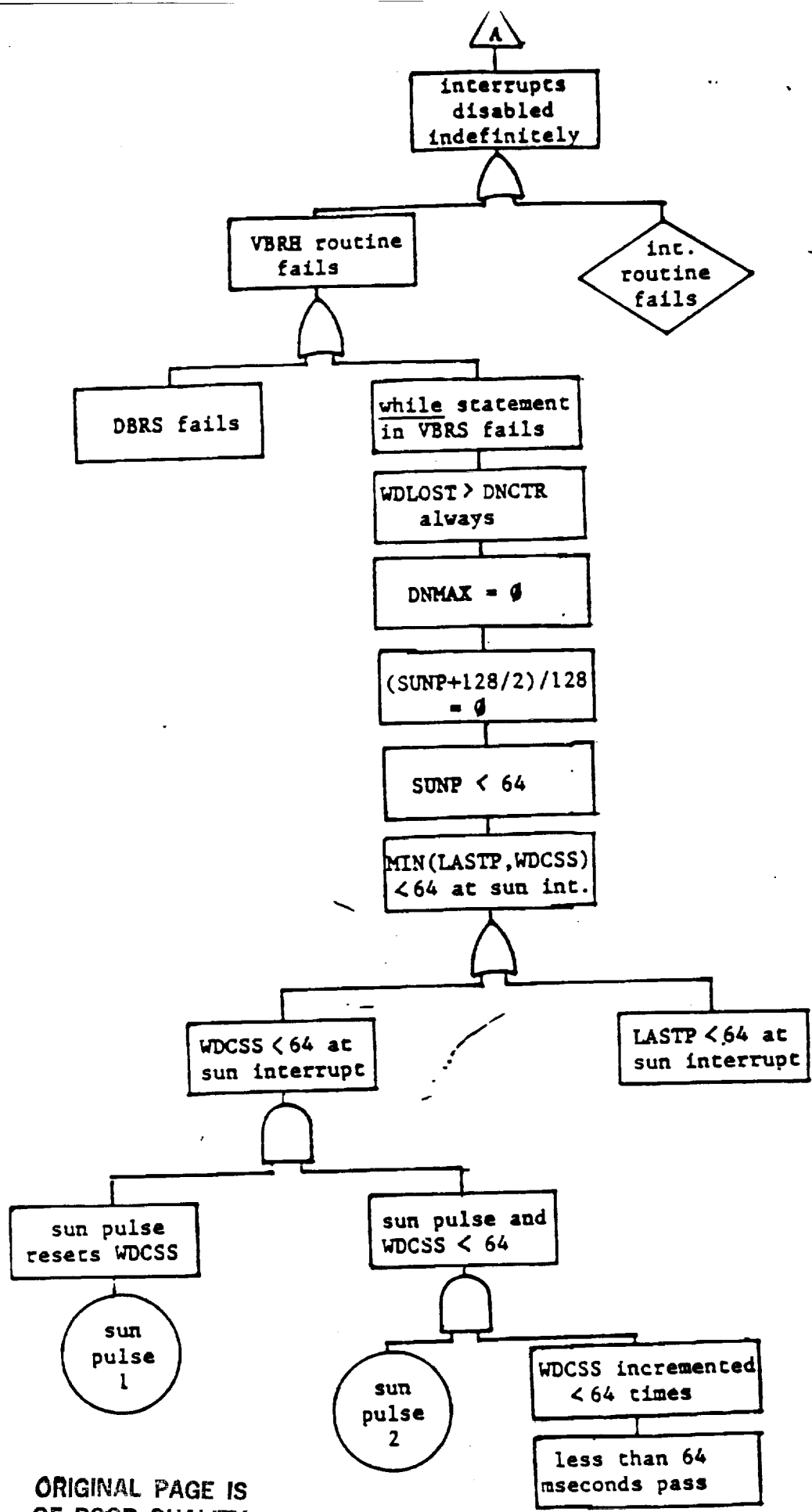
Figure 7. Firewheel Spin Control - Software Opens gas Valve

file location: 7

initial fault: FireWheel spins too fast



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Figure 9b. Boom Length Too Low (continued)

Node Label: Motor Failure  
Node Fault: Boom Motor Fails

Root Fault: wheel Spine Too Fast  
Fault Tree Name: wheel ftree

Session Name: Firewheel  
Author: Peter Harvey

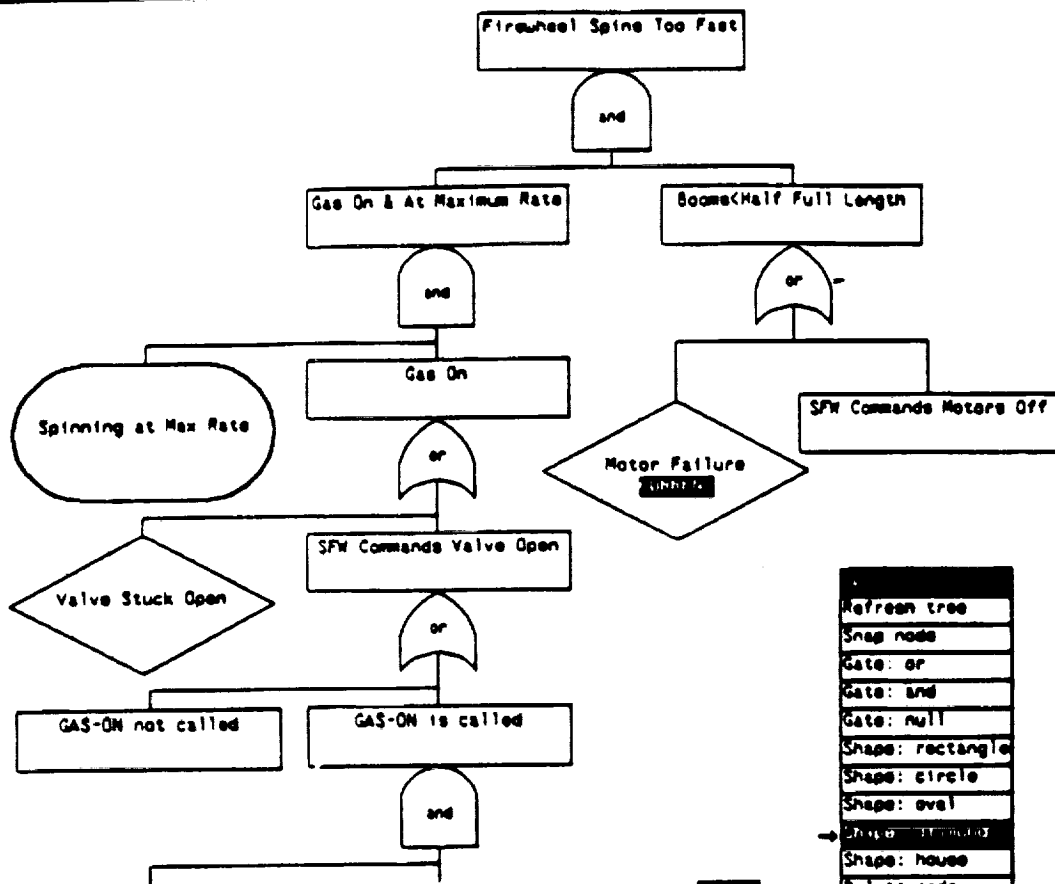
File Store Load Tree Add Node Help Delete Node Refresh

ADD CHILD NODE

Mouse Buttons: ☐ Select/Move node ☐ Add child/parent to current node ☐ Select an option

The fault tree has been saved.

Print Form File wheel.pic



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Software Fault Tree Analysis useful to:

- identify software faults potentially leading to accidents  
OR “verify” (increase confidence) they do not exist
- provide information for testing
- provide guidance for content and placement of run-time assertions (fault detection)
- provide information on fail-safe requirements

## ASSESSMENT OF RISK

Certification of system partly based on system safety report including

- Description of procedures used to ensuring software safety
- Results of software analyses
- Quantification of risk.

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## Physical devices vs. software

- They “fail” differently: failure vs. design errors
- No historical reliability and safety assessments on standard designs for software.
- Repair involves redesign rather than replacement by equivalent part.

## Software Reliability Models

- Estimation of reliability model parameters made from measurements of time between failures during testing.
- Most of controversy rests on assumptions models make about software. Some typical ones:
  - Software faults, and thus the failures they may cause, are independent of each other.
  - Inputs for software are selected randomly from an input space.
  - Test-input space is representative of the operational input space.
  - Software under test constitutes a functional unit to which no new software modules are added during testing.
  - Each software failure is observed.
  - Faults are corrected without introducing new ones.
  - All errors are of equal severity.
  - Each fault contributes equally to the failure rate.
  - No major revisions or changes in staffing or aspects of development or maintenance environment.

- Even if believe models, cannot exercise enough during testing to provide very low failure probabilities with high confidence.

Doug Miller:

To assure failure rate less than  $10^{-9}$  failures/hour, must test for more than  $10^9$  hours and experience no failures (110,000 years of testing).

To be 99% confident that failure probability less than  $10^{-9}$  requires  $4.6 \times 10^9$  test cases without failure (525,000 years of testing if unit of time hours and assume reasonable amount of time to execute a test case).

## CONCLUSIONS

- Standard reliability and fault tolerance techniques will not solve the safety problem for the present.
- A new attitude required:

Looking at what you do *not* want software to do along with what you want it to do.

Assuming things will go wrong.

- New procedures and changes to entire software development process will be necessary.

Special software safety analysis techniques are needed.

Design techniques, especially eliminating complexity, will help.

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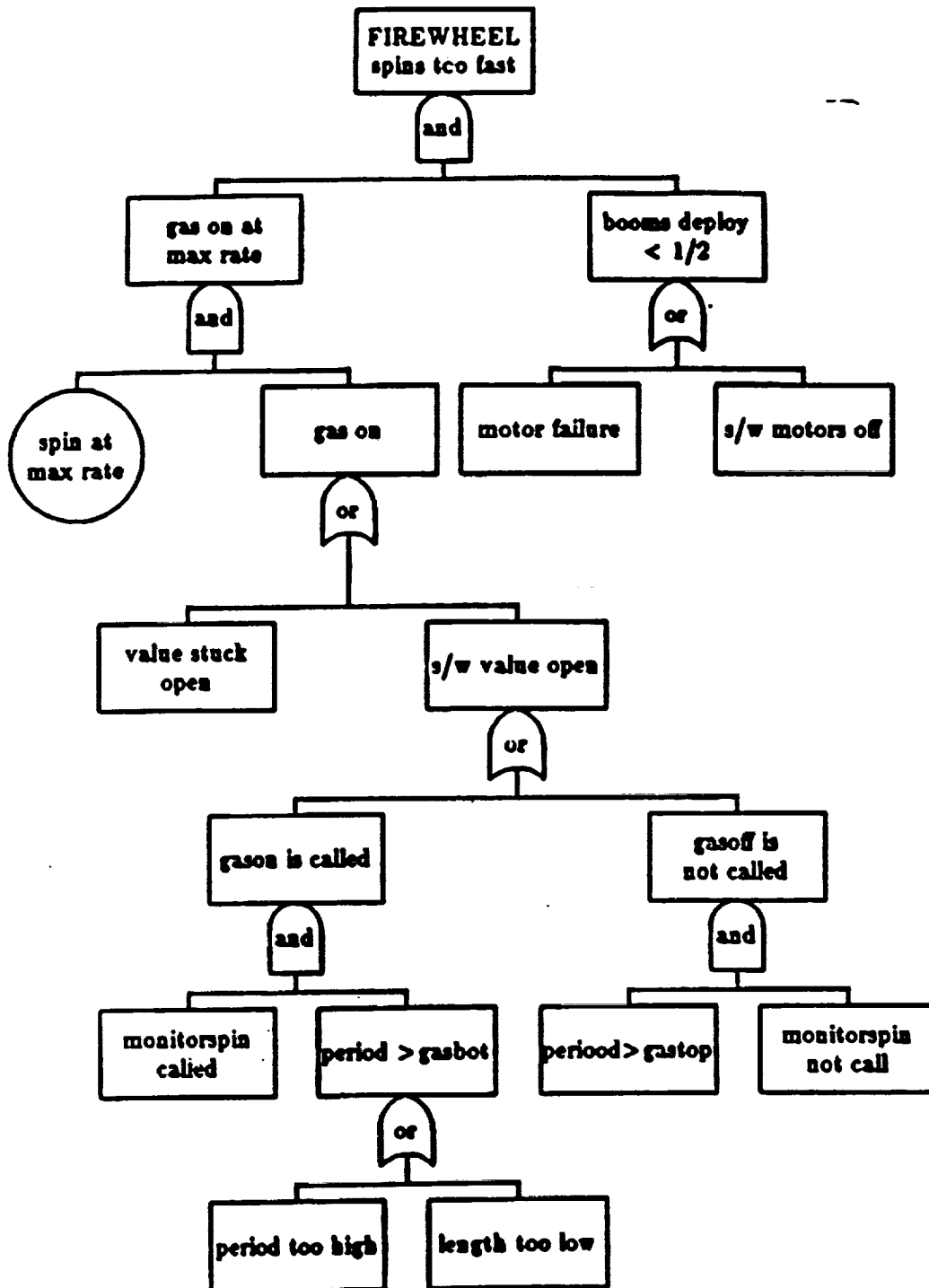
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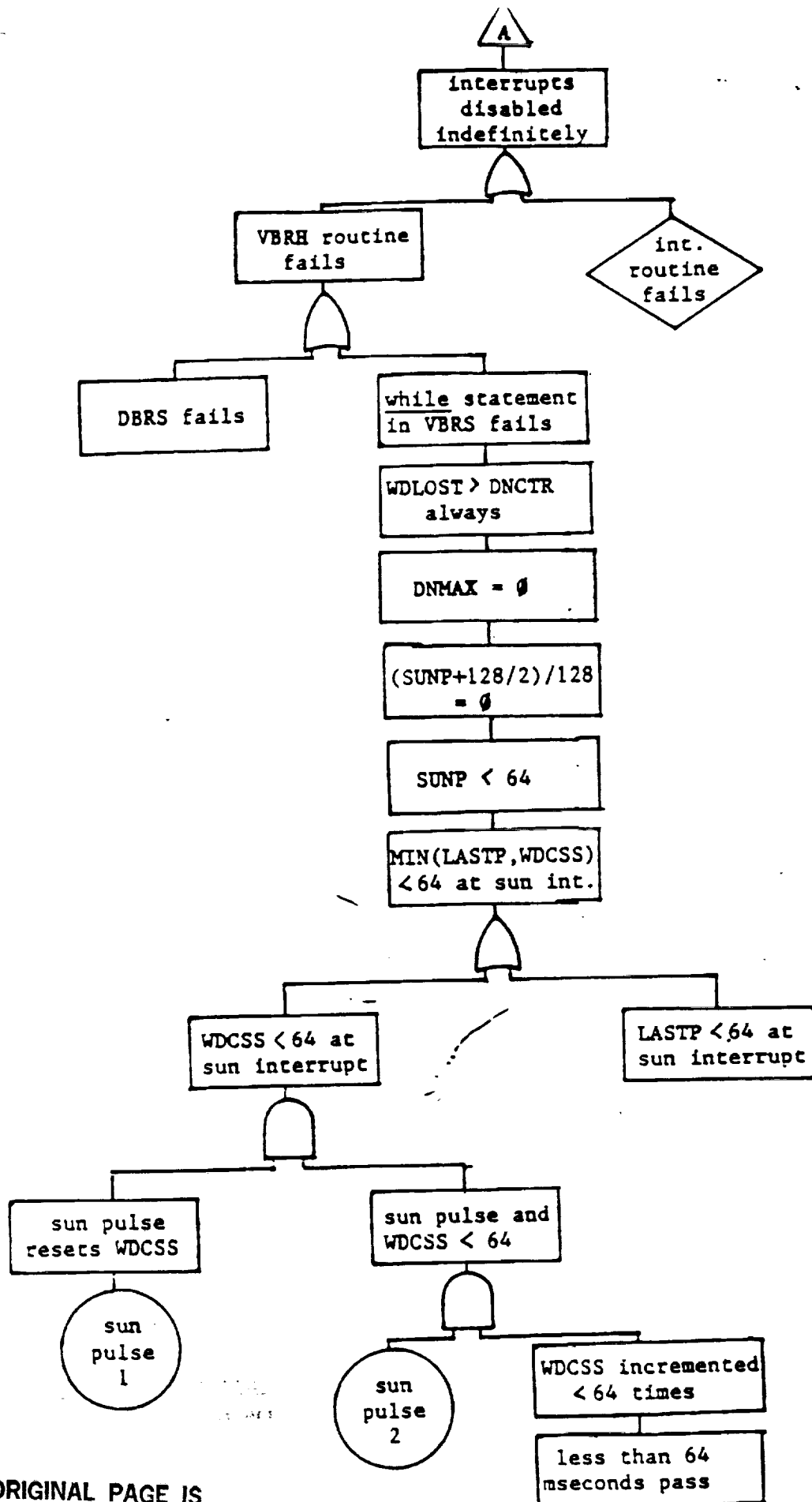
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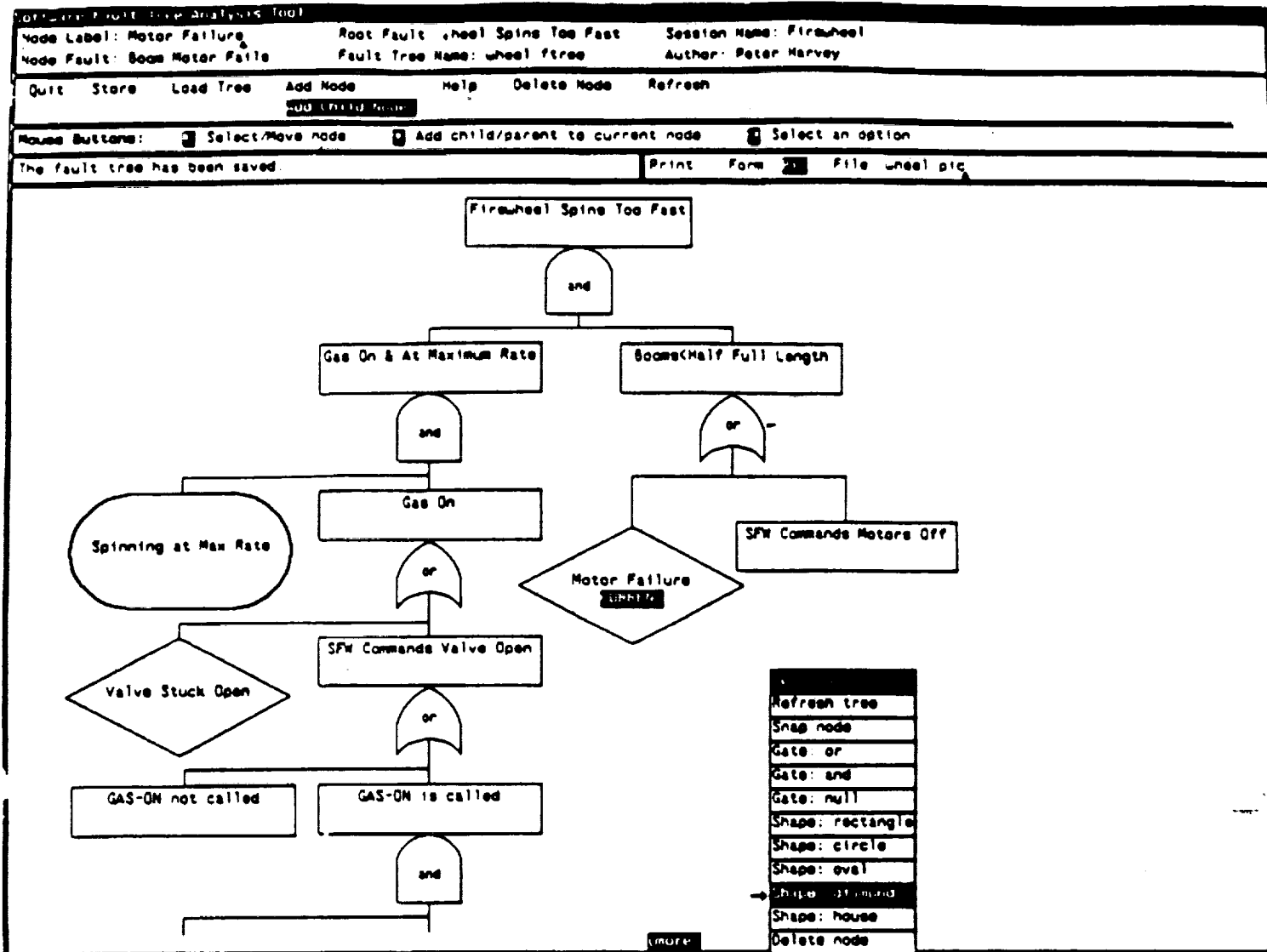


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Figure 9b. Boom Length Too Low (continued)



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